JIGSAWS AND JUGGLERS:

DISPOSITION, DISCOURSE, AND DECISION-MAKING

IN THE ASSESSMENT OF STUDENT NURSE PRACTICE

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CONTENTS

Abstract

This research is concerned with the assessment of student nurses' practice, implementation of which has been considered problematic since the move of initial training into higher education. It examines clinical nurses' accounts of assessment, and rejects an approach based on identification of competencies as too rationalistic for a situated practice. Insights from, in particular, Foucault, Deleuze, and Derrida were used to analyse practitioners' alternative discourse of practice, and the processes of self-constitution and decision-making.

Eighteen practitioners from different settings were interviewed in depth about how they determine acceptable performance. Three participants were interviewed twice to develop ideas arising from the first round of conversations. Practitioners' accounts challenged the conventional understanding of assessment, and the construction of practice implicit in current policy. The analysis suggests a more fluid, un-predetermined understanding, characterised by hesitation and uncertainty, though without losing a concern with safe practice.

Several implications for policy and practice are presented. These require a shift of authority towards practitioners' situated judgements and away from predetermined outcomes, both in respect of programme planning and policy guidelines on the specification of standards. A new alliance is proposed to encourage a more authentic engagement with the process from both clinical and educational practitioners.

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Chapter 1: Introduction

This study examines how clinical nurses account for their practices in the assessment of student nurses. The work challenges more conventional approaches to this problematic issue, and rejects the rationalistic explanations adopted in much previous work. Using insights from the work of Foucault (2002a), Deleuze (1994), Derrida (1995) and others, I will show how the practitioners in this study resisted the prevailing discourse of practice, and constructed an un-predetermined version in its place. Further, I will show how they built a more mobile model of themselves as nurses than is possible based on the technical-rational model promoted in current policy. This understanding of the process will be shown to present impossible dilemmas for participants; consequently, I will argue that practitioners' situated judgements warrant authority in their own right when making decisions about student progress.

I had commenced this research with a view to identifying whether practitioners might have their own definition of competence, the dominant concept in current policy and training programmes. This could then be incorporated in assessment documentation as a more accurate representation. I eventually understood this as too rationalistic an approach for a situated practice, and saw the necessity of avoiding the assumption that this was capable of circumscription. As I will show, such assumptions have to date provided no effective answers. I was also aware that the interviews themselves were situated events, and my location as a teacher of nurses was a likely barrier to practitioners' willingness to share with

me what they claimed to be looking for. At least some participants seemed to perceive their status in our relationship as subordinate, regardless of repeated assurances to the contrary. Accordingly the research is an analysis of practitioner accounts, rather than a claim to some fundamental truth, which I argue cannot be achieved.

Representing practice

The idea for the research emerged from my observation that there is sometimes a surprising discrepancy between the outcome of assessment of particular students, and what would have been expected, given prior knowledge of the same individuals. It occurred to me therefore that, when making their judgements, practitioners might be using something other than the given criteria, yet the latter claimed the support of all sectors of nursing. This was an important possibility since, if practitioners held another way of thinking about practice, this was likely to influence their judgements of it (Fish and Coles 1998). That there were even occasional discrepancies in decisions reported implied an influence beyond the given understanding.

The reductionism of the recent policy emphasis on measurability has promoted a technical-rational view of practice and its assessment. This has been aimed at introducing precision, and a model of practice capability that can be universally and objectively applied, in the name of a new form of professionalism. As the general orientation to this approach grew, the practice-learning component of programmes came to be referred to in terms of competencies (e.g. Phillips et al 1994). More recently policy statements

confirmed a competency-based approach as the preferred model for assessment of practice (UKCC 1999, 2001). In keeping with the changing model of professionalism more generally (*cf*. Perkin 1989), this has marked a significant change in the way nurses' expertise in practice is represented.

I will argue that this is an unacceptable, inappropriate way of thinking about practice, which should be rejected. This research recognises the situated, hence contingent, nature of nursing practice and its assessment; I will argue that the pursuit of an essential understanding is both inappropriate and unworkable.

Aim(s) of the research

The aim of this research was twofold. I wanted to expose any differences or discrepancies between practitioners' claims about assessment of student performance and the view promoted through policy guidelines. This would, in turn, inform policy and practice in assessment, the better to promote an authentic engagement in the process by practitioners. The aims were formulated in this way to avoid assuming that the process would necessarily be straightforward and rationalistic, as was implied by my original thinking; I had come realise that I may have to take account of factors other than isolatable reference points. If claims varied from the prevailing view, I wanted this to emerge, whether or not the process was understood, for instance, as discrete concepts or narrative descriptions. Thus, the first question was, what do participants say counts as evidence in a student's performance, and how is this deployed to determine acceptability?

Embedded within this were other questions: how do practitioners distinguish acceptable from unacceptable practice; is there any evidence of a hierarchical arrangement in the evidence they look for? The latter does not assume this as the case, but accepts accounts as presented; the former allowed that acceptability was not merely the mirror opposite of unacceptability, in a binary model of understanding. To assume a constant approach in this process would have implied a fixed understanding of practice, whereas I argue for a situated, hence variable, understanding. Indeed, variable judgements using predetermined criteria are difficult to explain otherwise. This led to the question of whether judgements varied over time or place; and, importantly, how was this explained by participants? This form of question was necessary to avoid limiting the options available to participants, or constraining them to an implicit fixed range of factors (*cf* Anderson *et al* 2001).

Claims for what is sought in students as aspiring registrants implies both a model of practice and of the observer as a registered practitioner; to seek characteristics of something other than this would be nonsensical. So, how do participants construe their practice and their nursing selves? How is each characterised? Through this, and, indeed, throughout the study I wanted to understand how participants positioned themselves in relation to the approved approach. What do they say, therefore, about how they deal with predetermined criteria in their assessments, particularly where there might be any conflict with their own claims? This introduced the question of their experience of the power-relations operating between the educational and clinical sides of training. I

anticipated that answers to these questions would help understand the extent to which participants own, are dominated by, or resist external definitions.

The Participants

Practitioners with a minimum of one year's experience as a mentor-assessor were asked to contribute from their experience of assessment. I wanted people with exposure to more than one student, to allow responses to be drawn from different personal experiences, in acknowledgement of variation between individual students. Eighteen practitioners volunteered, and were interviewed individually over a period of one year, a more extended period than originally anticipated. (This point will be addressed in chapter three.) Experience as qualified practitioners varied between three and over thirty years, and contributors were drawn deliberately from a variety of locations, organisational and geographical, to allow for the possibility of variation between settings. Three participants were invited for a second interview; their selection was based on points they had raised during our initial conversations, concerning what I saw as important emergent elements of the data as the analysis was developing, so that these could be explored more extensively.

Structure of the thesis

Chapter two examines the literature concerned with assessment and the notion of competence/ies[1] in the context of professional practice, taking account of the

[1] I will use this compound term where relevant in view of the increasing tendency evident in the literature to elide the two original terms (*cf*. for instance their varying use by authors such as Gerrish et al, 1997; Institute of Health and Care Development, 1998; Watson et al, 2002; Dolan, 2003; MacMullan et al, 2003; Ormrod and Casey, 2004; NMC, 2004, 2005).

interested nature of policy statements. Databases searched included Medline, CINAHL, PsychLit, BIDS, World of Science, OCLC; I also utilised the Google® search engine for any open access internet sources. Search terms included, in various combinations, assessment, criteria, competence/y/ies, nurse/ing education/training, policy, practice, professional/ism. The relationship between policy and clinical or educational nursing practice will be examined, particularly in relation to the concepts of competence and competencies. I will demonstrate how this has developed a particular discourse of practice, which excludes alternative, less easily measured conceptions (*cf*. Foucault 2002a).

Chapter three considers the methodology, and shows how the approach to data collection and analysis developed. I will illustrate the shift from a relatively rationalistic approach, based on attribution and correspondence theory (Jones and Davies 1965), to a more discursive understanding of participants' talk, informed initially from the work of Potter (1996) and Anderson *et al* (2001). I will show how I developed this to a more open perspective overall, informed from my reading of Foucault (2002a) on discourse formation and the constitution of self; Deleuze and Guattari (1994) on knowledge and self; and Derrida (1995) on self, responsibility, and decision-making.

Chapters four to seven explore the data utilising each of these perspectives in turn, starting with the process of attribution, inferring disposition from particular behaviours as a criterion for acceptability. Chapters five and six show how participants' accounts, presented in this way, served to construct both an alternative to the prevailing discourse of practice, and a model of their nursing

selves, which are more mobile and flexible than is afforded by modernist approaches aimed at clarity and precision (*cf*. Fish and Coles 1998; Francis 1999, 2000). Chapter seven demonstrates the undecidability of the task of assessment, arising from the complexity and particularity of each situation encountered, and participants' obligation to the student as other (Derrida 1995).

My analysis challenges the current approach to assessment in policy and practice. It has important implications for practitioners' engagement in decisions on assessment at national and local curriculum design levels. It points to a more open way of thinking and teaching about nursing as professional work. I will argue for a more egalitarian relationship between policy-makers, teachers and clinicians. The indeterminacy of clinical situations and participants' nursing selves render judgements of performance incapable of prior specification, and invoke an un-predetermined approach to assessment. I will argue that a genuinely public debate is needed to reduce the distance between policy-makers and practitioners, to make decisions relevant and consistent as well as accountable. The background to the focus of study will now be considered in detail.

CHAPTER 2: Review of Literature

This chapter will review the background to the changes which have affected the manner of assessment of nursing students' practice development. Issues deriving from a consideration of policy, professionalism, and the nature of practice – in particular its representation as competence/ies – will be examined in turn below. Nurse education policy development in the 1980s and '90s sought to strike an uneasy balance between a number of competing influences. First, nurses needed to be trained to meet the future manpower needs of the NHS (UKCC 1986). Second, there was a demand, from different sections of the nursing body, to raise the status of nursing knowledge (Payne 1997; White 1986). Third, it was argued that this is tied to the need for a theoretically informed basis for practice; criticism had been levelled at the presence of ritual in nursing, based on custom and practice, and a more critical approach has been advocated (Ford and Walsh 1994; Walsh and Ford 1989; UKCC 1986). Finally, health care managers want nurses, like other occupational groups, to fulfil their obligations in terms of efficiency and effectiveness, issues which have grown in importance with the rise in managerialism and the concern with control and accountability (e.g. Stronach *et al* 2002; DoH 1999; UKCC 1999; Perkin 1989).

POLICY DEVELOPMENT: NEED FOR CHANGE

Calls for a different form of training and preparation go back several decades; reforms proposed by Briggs (1972), after a short delay, informed the proposals

made in *Project 2000: A New Preparation for Practice* (UKCC 1986), which placed emphasis on the need to make more explicit the knowledge base accessed by nurses in practice (UKCC 1986). Ryan (1989) characterised this as a profound change for the status of nursing students: they would now be seen as students *per se* rather than as apprentices, *ergo* employees. The subsequent move into higher education institutions (HEIs) was accompanied by profound changes in the way nursing knowledge and practice was articulated (Chandler 1991; Sutton 1996). Previously, practice was characterised by a technical-practical model, based on a system of apprenticeship learning (Ryan 1989): students were assessed mainly on the basis of clinical activity *in situ*. This record and representation of the nurse's abilities was supplemented by a relatively short written form of examination concerned with a range of clinical conditions or underpinning knowledge. This in turn focused primarily on disease and a range of common nursing interventions, at a time when nursing knowledge was subordinated to medicine, and characterised as low-status female work (Lorentzon 1990).

With the introduction of the HE Diploma initial qualification programmes placed greater emphasis on assessment of academic achievement as a deliberate policy following *Project 2000* guidelines. This has been judged to be an explicitly academic characterisation of practice (UKCC 1999; Gilmore 1998; Gerrish *et al*. 1997; Ryan 1989), using a wider set of criteria for success than its predecessor model. The intention of this new form of preparation was strongly supported in Government policy on the grounds that there was a need to ensure that practitioners were adequately prepared for the increasing and

changing demands of the health service of the future. However, it is a widely held view that the format was more representative of how educationalists and theorists think about nursing work than of the views of practitioners, who, it has been claimed, regard them with some scepticism (UKCC 1999; Payne 1997; White 1986). Thus, the basis of further policy change was already erupting from this fundamental innovation.

It is also interesting to note that the change in the nature of nurse education occurred at a time when professions were being challenged to make their expertise more explicit and measurable, in the interest of greater public accountability (Chandler 1991). Universities were under pressure to make their programmes more vocationally relevant, and more obviously useful to the workplace. This meant, of course, that outcomes, intentions and practices needed to be made more measurable, while nursing education was about to become more academic. Following the alleged failure of the Project 2000 model of training (UKCC 1999), policy has been further modified, to install an explicitly outcomes-led, competency-based approach to curriculum development, more in keeping with the prevailing discourse of accountability and utility.

Policy: consensus or imposition?

However, views on the nature of policy formation are divided. Colebatch (1998) and Freidson (1994) take the view that, rather than ever being definitive, it is constantly being re-formed, ultimately determined by the interactions between interested parties. According to Colebatch (1998), for instance, policy is a dynamic process in which statements are made, reacted to, and modified over

time. From this perspective it involves statements of preference emanating from multiple sources, so that, though presented in more or less definitive terms, it eventually comprises and accommodates multiple perspectives. As an example, reviews of nurse education provision (UKCC 1986, 1999) took soundings from anyone termed a stakeholder, professional or otherwise. Thus, it could be said that dissatisfaction with the format for training, combined in the case of *Project* 2000 with the incongruity of the timing of the move into HE, led to change which was representative of, or a compromise between, the interests of all parties. Policy was then formulated, leading to guidelines for curriculum development and awards (NHSE 1999; WNB 1995a), or to standards for health care delivery by newly qualified practitioners (DoH 1999; NAW 1999) agreeable to all.

This is, however, a benign view of the process, which ignores the effect of power relations amongst those involved. The culture of nursing has been characterised as one of surveillance (Pask 1995: reviewed in more detail below), in which dissent has been actively discouraged. It is therefore unlikely that beliefs at odds with the prevailing view will be aired publicly for fear of punitive sanctions. In exploring this problem I found Bauman's (1999) model of the policy process useful as a way of conceptualising it. He describes an ancient model composed of the *Ecclesia,* or policy-making body, the *Oikos*, the private individual or household, and the *Agora*, the market place or public forum. Policy is formulated to provide direction for individual social action, and to maintain order and social cohesion (Colebatch 1998). Bauman (1999) argues that there has always been an acknowledged and proper place in this process

for public discussion and debate – the *Agora* – in which differences with, and challenges to, policy could be worked out. However, he considers that the latter has been lost in the current climate, suggesting that it has been attacked from the site of the *Oikos*. In the context of the system and traditions of governance in nursing the *Agora* can be seen to be absent, but in this case, I suggest, the primary influence comes from the site of the *Ecclesia*, and this has implications for the representativeness of published policy.

Following an argument presented by Heiskala (2001) the balance of the effects of power will depend on the possession, or belief in the possession, of a winning strategy by one or other in the relationship. Heiskala draws on Foucault's concept of power to develop a model which moves away from a conventional zero-sum game, adopting the argument that several conditions apply in a power relation. There is always a game or strategic analysis of a given problem present; there is an absence of violence, though constraints on action still operate; relations are institutionalised and rationalised, that is, there are (discursively) established means of interaction; and a power relation is not the only type of relation between those involved. There is always the option (freedom) for those involved to resist the desires of the other, even though the actions of *a* will re-order the actions or possibilities for *b*. Without the freedom to resist, Foucault argues that the relation is one of mere domination (Hindess 1996).

Thus, although extensive consultation is undertaken with practitioners prior to the introduction of new requirements, this is unlikely to generate substantial

dissent. Where any new policy direction appears to satisfy the interests of one or other faction of the group, it will be welcomed; where it is otherwise, it is unlikely to meet overt sustained resistance. This is not, however, to say there will be no resistance at all in these circumstances (Foucault 1977b, 2002a), and more will said about this shortly. Crucially, the effect of the power relations between nurses in practice and their managers and governing bodies would impede any open discussion or dissent. This has the consequence that a genuinely open debate is unlikely to occur, and policy could be imposed *as if* generally accepted, since nursing lacks a *de facto* forum for open debate. The traditional governance of nursing seems to fit well with Bauman's (1999) model of the policy formation process.

Nicoll (1999) offers a further critique of conventional policy analysis; on her account this has commonly underplayed the interested stance of policy-makers. It tends, she considers, to adopt a positivist-realist approach, as though the conclusions expressed in policy statements simply reflect how things are, or should be. Also taking support from Foucault (e.g. Foucault 2002b), her critique makes the important point that those who occupy more powerful positions in the hierarchy of influence are consequently more able to influence the dominant discourse of need, and are thus more likely to prevail. For my own study, changes in the pattern of nurse education are held to have had considerable appeal to NHS managers, in the form of a more knowledgeable, *ergo* skilled, workforce; increased reference to competence/ies appeals to the prevailing concern with measurability and accountability. The achievement of particular goals and the means of their identification are presented in policy as though

these were straightforward, self-evident choices. It is interesting that, despite the apparently benign tussle suggested by Colebatch (1998), he nonetheless argues that policy development normally shows a number of structural features, for instance coherence, instrumentality, and hierarchy, concerned respectively with organised, goal-orientated implementation, and authority to impose goals and actions, a view more in keeping with Heiskala and Nicoll.

In this respect, Gerrish and colleagues (1997) undertook a review of related literature, and an analysis of documentation from nursing and midwifery programmes at different levels. This was against the background in which, though guided by the same overall policy outcomes, some freedom was allowed for each provider institution to interpret requirements in its own way. Their study examined programme documents to compare outcomes, and the detail of assessment protocols. Not surprisingly they found that there was considerable variation in the way each institution had interpreted official requirements, so that what was presented to practitioners by way of a guide for assessment of practice showed considerable variation. The conclusion drawn was that such variability meant that one centre's programme could not easily be compared, or judged equivalent to, another's. This was considered a flaw in provision, since all programmes operate under the same regulatory framework (UKCC 1989).

There is here an explicit expectation that the outcome of each programme should be directly comparable. This may be desirable and common enough as a policy goal, as Colebatch (1998) suggests, representing coherence, or unity,

in planning and delivery. But, as Barnett (1997) argues, such totalitarian – to borrow a term from Bauman (1999) – standardisation is hardly in the interest of provoking critical debate as a central part of professional practice; yet this is an established principle of higher education, which nursing ostensibly wants to embrace. Importantly, in the Gerrish study, the possibility that each institution had simply maintained some theoretical consistency with its own interpretation of the meaning and implications of the outcomes specified in regulations is demoted to a secondary issue at best.

Constructing the policy discourse

The managerialistic characterisation of practice, then, allowed the UKCC's Commission of Enquiry (UKCC 1999) to claim that 1990s nurse education was ineffective, through claims that newly qualified practitioners were not competent at the point of registration. Concern with technically-defined effectiveness was expressed in the context of a general concern with the assessment of competence applied to most professions (MacAleer and Hamill 1997). The use of the term competence (used almost interchangeably with its more reductionist plural form, competencies) in reference to the outcomes of initial training programmes, and as a way of characterising nursing practice, grew throughout the 1990s (e.g. Chapman 1999; DoH 1999; NHSE 1999; Milligan 1998; MacAleer and Hamill 1997; Phillips *et al* 1994; Bedford *et al* 1993). Much of what was written over the decade prior to publication of the Peach report (UKCC 1999) was concerned with the definition and measurement of competence, the primary driver in measuring effectiveness.

The choice of terminology in nursing seems to have been influenced by the publication of Benner's influential text *From Novice To Expert* (Benner 1984). In what she characterises as a phenomenological approach to studying nursing – hence in a search for the essence of excellence in practice – she used self-reported exemplars in which the individual practitioner had, by her own account, made a difference. Through this Benner sought to illustrate how nursing expertise develops following initial qualification, differentiating between the rule-bound judgements made by junior clinicians and a more intuitive – embodied – form of knowledge utilised by experienced practitioners. She applied the term competence to the stage of development when the application of rules to situations becomes less stilted, and action therefore more fluent.

As initially adopted in nursing in the UK, the term referred loosely to the thirteen learning outcomes specified in regulations by the UKCC (1989), even though the term does not actually appear in these. That Benner's research used qualified nurses as respondents has been forgotten – or, from a Foucauldian perspective (e.g. Foucault 2002a), excluded – in the construction of the discourse of practice. Similarly, the point that novice practitioners, according to Benner, still access and utilise rules to guide action has been overlooked. In a rare enough example from the wider literature, acknowledging initial qualification as the starting point for Benner's characterisation, Daley (1998) comments,

> In studies with nurses and pilots it was found that novice professionals tend to govern their practice with rule-oriented behavior … Since novices have little experience with real situations they must rely on the rules they have learned in their prepatory [*sic*] education to function. (www.edst.educ.ubc.ca/aerc/1998/98daley.htm)

Daley recognises that Benner's work has implications for *post*-registration educational programmes, but UK policy on nurse education failed to identify (ignored) this, and simply adopted the novice to expert model of progression as the basis of design for *pre*-registration programmes. In this sense at least the term is out of place. Its use has led gradually to more prescriptive guidelines for pre-registration programmes (e.g. WNB 1995a, 1995b; UKCC 1999; DoH 1999; NAW 2001) with a requirement that educational institutions ensure that students are achieving required competencies, implying that these are clearly enough defined and essential to good nursing practice, at the point of qualification.

Control and the discipline of nursing

The increasing orientation to technical descriptors to specify training outcomes serves potentially two functions. First, it articulates practice in an apparently rational way, making practice knowledge both explicit and measurable. It also produces a greater degree of control over the workforce – rendered more predictable, with variation and risk reduced – than the more open, flexible approach espoused by the contemporary (*viz.* higher education) model for training. It might be argued that the increase in criticality promoted in the newer model of nursing courses had produced a less compliant practitioner (though not necessarily a less competent one) in need of containment. Technical specifications (understood as more explicitly rule governed behaviour) take on the appearance of disciplinary (*ergo* professional, in its contemporary usage)

knowledge, while allowing the exercise of greater control, as Foucault illustrates in *Discipline and Punish* (Foucault 1977a).

Thus, the growing emphasis on competencies throughout the 1990s, and the subsequent consultation prior to the introduction of a new curriculum, are arguably only superficially an example of interactive policy development, implying that an agreed understanding of what is involved has been achieved. Given the dissatisfaction expressed, formally and anecdotally, about Project 2000 programmes (UKCC 1999; Payne 1997), these policy developments show a subtle form of coercion (*cf*. Nixon *et al.* 1997). Much of what is taken as agreement simply ignores the possibility that power relations play a part in how or whether views are expressed, and in the relative influence that these different views might have in determining policy. Unless practitioners are genuinely signed up to current requirements, it is possible that there will be no change in individual practices during assessment, regardless of what is recorded on paper; variability in performance is likely to persist.

The policy development process becomes more invidious when seen from this point of view: members of a group are encouraged to internalise such specifications and values, ostensibly as a part of their professional being (Fournier 1999; Lorentzon 1990; Foucault 1977a, 2000). On this account, the responsible practitioner will come to monitor her or his own practices using imposed criteria for acceptability: policing a self defined by others. Responsibility for others' development is undertaken on behalf of those hierarchically superior, rather than in the interest of the student *per se*, with the

purpose of reproducing the externally defined good self. Foucault (1977a) illustrates this point in his account of the surveillance of prisoners: being watched without being able to determine whether or not this is the case. Rules are given, expectations are set, and subjects adopt others' requirements to govern their behaviour. Action outside these parameters is problematic (though, as I shall argue later, not impossible). While Foucault's examples come from penal and militaristic sources, the point sits easily within nursing – as a formal occupational body grown out of military adventure, and adopting many of its hierarchical mores – where, traditionally, strong disciplinary controls have been in place since its inception as a formally trained workforce.

An interesting example of this is available in work undertaken by Pask (1995), who illustrated that the self-monitoring tendency still applies, whereby practitioners give priority to the potential risk to themselves of disciplinary action, if their clinical decisions are not accepted by senior colleagues. Pask explored clinical practitioners' ways of making clinical decisions, through a combination of observation and follow-up interview, asking to what extent their decisions were a response to their interpretation of individual clinical problems (i.e. based on professional judgement), and how the decision to act in a given way was reached. Another way of understanding this is that she was interested in the kind of knowledge accessed in decision-making. She found that in practice they did not always do what they thought would be the right thing in the circumstances, if, for example, this involved significant variation from stated protocols. Instead, they would comply with a written protocol, in a manner

described as looking over their shoulder: being called upon to justify variation was considered too threatening.

So whose knowledge counts?

Pask is clearly allowing that there are different versions of knowledge at work here, and that different readings of the whole situation will influence how an individual acts: that is, action is not undertaken without reference to context. The disturbing (though perhaps not entirely unexpected) conclusion was that practitioners operate within official guidelines even though they consider them restrictive. This creates the appearance of professional behaviour, managerially defined (Fournier 1999; Shain and Gleeson 1999), yet their reasons, invisible to simple observation, reflect mere compliance rather than internalisation or conviction. This understanding of Pask's findings shows similarities with the discourse analytic perspective advocated by Anderson *et al.* (2001) and Potter (1996), in which attributions made by observers are influenced by their awareness of the implications of their statements for their own status. (See below for a more detailed consideration of Anderson *et al.*'s study.)

There are some similarities here with Giddens' notions of practical and discursive consciousness: awareness of what the situation demands, arising from individual experience, and awareness of what is discursively permitted (Giddens 1984). The strength of the discursive presence can be seen in Pask's analysis. On the one hand, practitioners make clinical judgements by reference to criteria different from those presented in protocols; on the other, they choose not to display these openly. That is, their actions are governed by the dominant

play of another – the winning strategy (sanctions against the practitioner), as Heiskala (2001) might say. Thus, decisions for action come from practitioners' situated understanding weighed against their discursive consciousness, and the potential cost to them of non-compliance. Hence, their understanding of the situations they encounter encourages transgression of the boundaries of accepted wisdom (Foucault 1997b); but their desire not to be constrained by the prevailing view in this case remains a private affair. Having covertly explored the possibilities of transgression, they move back within the given boundaries, since they will be unable to make their case stick. Such a move sustains the prevailing view of knowledge in a process reminiscent of Giddens' duality in structuration.

So it seems that here, practice from a practitioner point of view needs to be understood by reference to different criteria than the publicly stated inscriptions of good professional behaviour (*cf*. Fournier 1999). This invokes a less universal understanding of the kind of knowledge accessed by practitioners, an understanding more akin to traditionally defined professionalism (*cf*. Ohlen and Segesten 1998; Banks 1996; Freidson 1994). If organisationally defined protocols are understood as examples of the thing to do in given circumstances – that is, they represent the clinical application of competencies – then they are problematic for Pask's practitioners. Indeed, it is notable that one service provider (though not the only respondent expressing difficulty in this respect) cited by Peach in his final report to UKCC, comments that

> Competence at registration will change over time as roles and functions develop in response to many drivers affecting the provision

> of health care. It is not the nature of professional work to define it by tasks and skills. (UKCC 1999, para. 4.63, p. 44)

Interest and representation

A Foucauldian analysis of policy development in nurse education points to domination by those whose interest is managerialist in nature (Foucault 2002a). Managers and other policy-makers – both government, and a governing body whose remit is set by statute – can direct the public discourse of practice through a greater opportunity to influence the language in which it is expressed. Thus, good practice has come to be associated, or is even synonymous, with the terminology of a new form of professionalism, concerned with accountability, measurability, effectiveness, and efficiency, ostensibly encapsulated in the term competence/y, established through repetition and the exclusion of other terminology. However, in this usage, as Shain and Gleeson (1999, p. 450) so eloquently put it in their critique of changes within further education, " 'professional' is used as a[n] … adjective that is uncoupled semantically from professionalism …" to indicate an efficient, business-like approach to work. Delivery-focused ability is easier to identify than client-centred professional judgement, for instance. The juxtaposition of Benner's terminology – which confers credibility – and the increasing focus on competencies as the managerialist movement took hold (Barnett 1997; Wolf 1995; Perkin 1989) brought the terminology of competence fully into the language of nursing, as a taken for granted, legitimate entity.

Foucault (1977a) has shown how this approach can be understood as operating in the interest of those who wish to obtain control over others, through his analysis of the historical application of 'discipline'. The potential of the multiple meanings of discipline, even in its English translation, is worth keeping in mind here: discipline as (self-)control; discipline as punishment; discipline as a discrete defined body of knowledge. He has shown how individuals are shaped and constituted by influential others: good practice is captured by detailed prescriptions of action, just as competent practice is held to be captured in the present context by competencies. Appropriation of the definition of a body of knowledge and practice effects control of one group by another, and brings the potential for the application of sanctions. In this sense, at least, influential groups can obtain control over others, including how they define themselves.

Since the adoption by the NHS, in 1997, of funding responsibility for all pre-registration nursing programmes, the NHS has not only an interest in programme outcomes, but the opportunity, through control of finances for the whole nurse education project, to dominate debates about the nature of practice for which its trainees are to be prepared. In formulating policy which *claims* the support of the more traditionalist body of practitioners (managers and clinicians: Payne 1997) it strengthens its authority in demanding change, and leads the construction of a more technical-rational discourse of practice to replace the more academic version promoted through Project 2000. In the guise of a negotiated solution, and using the language of a redefined professionalism, it imposes its plans for the nursing workforce. Thus, where

Nixon *et al*. (1997) point optimistically to a version of professionalism in which activity is characterised as interactional and negotiative, Colebatch's (1998) suggestion seems more accurate: that hierarchy is often invoked when creating the strategy for action, and combines powerfully in the present context with the appropriated authority of the dominant players to shape professional activity, through a coercive, rather than negotiative, process.

That the term competency/ies – hence the technicised version of nursing practice – was becoming established in the language of practice was signalled most clearly by a major study commissioned by the English National Board for Nursing Midwifery and Health Visiting (ENB) in 1991. Undertaken by Bedford and colleagues, it explored assessment of practice within the new Project 2000 programmes (Bedford *et al* 1993); the research report was published 2 years later, and followed in 1994 by a further report making recommendations for practice assessment (Phillips *et al* 1994). The study will be reviewed in more detail in the next section. However, its importance in the present discussion is evident in the title of the project: "*Assessment of Competencies* in Nursing and Midwifery Education and Training (the ACE Project)" (italics added). The study is one of the first explicitly to refer to the outcomes of nurse educational programmes as competencies, even though UKCC regulations at this time had only set down a number of learning outcomes (UKCC 1989). It is notable that these were considerably broader than the generally understood concept of competencies (e.g. Wolf 1995), and only three of the thirteen were actually based in practical application (Whittington and Boore 1989).

The adoption of this technicised, ostensibly measurable, model of practice has implications for both nurse teachers and clinical practitioners. It is not merely a convenient way of expressing the manifestation of nursing knowledge and practice; it delimits what needs to be known or shown by restricting it to the ostensibly measurable. A focus on competencies as a representation of practice, as I will show below, is an impoverished and weak way of characterising nursing practice, and runs counter to its claims to be a complex, holistic kind of work. For teachers, it has the potential to render them little more than production engineers; clinical practitioners become technicians, working with a technical-rational model which underestimates and decontextualises their work.

COMPETENCE AND PROFESSIONALISM

Girot (1993) would have it that the concept of competence is over-defined; the plethora of investigations, to define it better, would suggest that it is ill-defined. Both cases are likely to lead to contradiction and confusion in use, as Gerrish *et al* and others have testified. Nevertheless, it is now interwoven with discussions of professionalism and accountability, and so we find the organisational priorities of the DoH to be highly visible in key policy-informing documents (UKCC 1999; DoH 1999; NHSE 1999): explicit references to job capability, standardised outcomes, practice-relevant material, transferability, differentiated levels of training, and production of better health outcomes. These notions are subsumed within the concept of competence, which is then claimed as the visible representation of the core of practice, rendering practice publicly

accountable, and making its essence explicit. The approach transforms professional practice into a collection of ways of deploying predetermined knowledge and procedures. By implication, since competence/y is the visible representation of acceptable practice, then it must be capable of being found.

However, the use of the competency model to represent professional work has been strongly criticised by Fournier (1999), who argues that competency statements instead, and within a discourse of professionalism, function as inscriptions of appropriate professional conduct, defined within organisationally determined boundaries. Practitioner autonomy is thus circumscribed through behavioural specification. Fournier's argument is based on a study of the way professional practice (in a business context) is identified through competencies. She found that competency statements were derived predominantly from personal attributes, not actions, but were then presented as specifications of professional behaviour. In this section I will examine definitions of competence as representations of capability, and review a number of studies examining the process of assessing competence in the context of nursing education.

The problem of definition

The final report of the Commission of Enquiry (UKCC 1999) distinguished 3 types of capability. It referred to fitness for practice (as suitability for admission to the professional register); fitness for purpose (that is, to undertake the role expected of them by the NHS as the major sponsor of nurse training, and employer of its graduands); and fitness for award (as the academic judgement warranting the award of a particular qualification). These are interesting

distinctions when viewed against a background of increasing concern with competence. It is not entirely clear how the first two differ, other than superficially, since the purpose of the first is to enable the second, while the third is part and parcel of the process of registration and recognition as a nurse. It also applies at two levels while still allowing access to the register and to employment. Thus the categories are unavoidably intertwined, and the notion of competence must apply to all three: to be considered competent is to be considered acceptable as a nurse (or, for the student, as a becoming-nurse). Without competence, an applicant cannot be admitted to the register; and without registration a person cannot be employed as a nurse. Without the award, neither of these is an issue. Hence, the assessment of competence applies in effect to the combined interest of practice *and* purpose *and* award with equal emphasis, and anticipates a more global judgement than is implied by its presentation in competencies; the latter has merely been euphemistically renamed fitness for practice.

Attempts to bring precision and consistency to the concept have singularly failed, yet over time the term has come to be used *as though* it has a clear, shared understanding, is visible in measurable activity, and it is only the poverty of our attempts to describe it that gets in the way. Pursuit of this holy grail has been undertaken despite Wolf's conclusion (Wolf 1995), that competencies have come to be acknowledged as profoundly problematic when converted into action statements. She observes that, given the exponential way that criteria developed over the preceding two decades to specify competencies more and

more completely, the “arbitrary quality of many decisions about [original statements of] content and standards” is revealed (*ibid*. p.106).

In the context of nursing practice the term also presents a contradiction: to claim that nursing is holistic (a good but possibly unpredictable thing) is incompatible with defining its practices in self-limiting competency statements (better for accountability). Close specifications contradict the self-critical goal of reform in nurse education. It is worth emphasising that current training is concerned with developing the ability to problem-solve, not simply to reproduce responses. As Purdey (1997) comments,

> ... the competency model is geared to the 'reproduction' of competent nurses *(sic)*, rather than the development of critically minded and potentially disruptive thinkers, who might choose to question the said qualities of 'competent' nurses (p. 199).

Disallowing practitioners the flexibility to make situated judgements implies that they cannot justify their actions, or determine what range of possibilities is available, a position reminiscent of Pask’s comments on trust as an essential component of practice. Training people for competence in this narrower way appears to liberate learners from the burden of putatively irrelevant material, but actually increases control over them (Usher and Edwards 1994). Flexibility in defining acceptability for practice – whether publicly declared or not – both acknowledges the context-dependent nature of nursing more authentically, and possibly provides a covert means of wresting some degree of control back to the practitioner. Close specifications of competence exclude the possibility of imaginative responding and thinking. There are links here to Foucault’s ideas on transgression of the boundaries of knowledge (Foucault 1977b), and to

Deleuze's metaphor of lines of flight (Deleuze and Guattari 1988): there are no ties to a fixed location when making sense of the social (clinical) world.

Chasing rainbows (1): the pursuit of nursing competence/ies

To date, attempts to tie down practice competence/ies have been akin to trying to capture rainbows. Studies of practice assessment on this basis have generally fallen into two camps. There are those that focus on the problems of interpreting and applying existing protocols based on interpretations of UKCC learning outcomes (e.g. Gilmore 1998; Gerrish *et al*. 1997; Bedford *et al* 1993). Then there are those that have sought to develop solutions, either in the form of better competency schedules (e.g. DoH 1999; ICHD 1998; Cox *et al* 1998), or in the manner of their application (e.g. Neary 2001; MacAleer and Hamill 1997; Fox-Young 1995; Phillips *et al* 1994). There is another strand of literature which has addressed itself to the appropriateness or otherwise of competency-based practice assessment. Indeed, the problems highlighted by this latter strand seem to be confirmed (even if retrospectively) by the investigations of effectiveness, consistency, and attempts at clarification. The arguments against competency-based assessment are consistent: they are based on the difficulties inherent in a technical-rational understanding of practice (Milligan 1998; Purdey 1997), which deploys narrow, static, acontextual descriptors of ability (Chapman 1999; Wolf 1995) in order to capture a complex practice with precision.

Bedford *et al* (1993), in the suggestively titled ACE Project, undertook a wide-ranging investigation over a period of 2 years, to examine whether current tools

and practices were effective in the assessment of the integration of theory learned with practice undertaken. To do this they explored the collection of evidence of assessment of learning, and reflection upon it. They used a range of strategies, including observation of practice and interview, acknowledging both the given elements of assessment, and those which implicated more interactive parts of the process. However, it is not clear whether this acknowledgement was of the possibility that practitioners involved in an interactive, dialogic process might have their own constructions of what counted as the focus of judgement; or whether they were simply negotiating an outcome based on given criteria. This study, as with most others exploring learner assessment in clinical settings, appears to accept the documentary givens, statements of what is to be achieved, as valid. Hence the study is primarily aimed at identifying the complexities of interpretation at the point of determining whether a student had achieved a satisfactory level of practice. Amongst the findings was the apparently greater effectiveness of assessment when the process involved dialogue between assessor and student, and when the opportunity for this was built into the programme and its assessment documentation. However, they also concluded – and this is a potentially crucial issue given the centrality of the clinical practitioner's role in student assessment (WNB 1997) – that preparation of assessors of practice did not commonly offer the opportunity to engage in the kind of critical, reflective process expected of students within these new forms of training.

There is a number of implications here. First, as MacAleer and Hamill (1997) rightly comment in their own study (reviewed below), dialogue involves

negotiation between (at least) two standpoints. What appears to be the case in Bedford *et al's* findings is that this dialogue is based on the given formulation of what will be taken to represent an acceptable level of practice development. This does not obviously take into account the more personal model of acceptability possibly operated by the practitioner, but relates only to his or her interpretation of what is already written. Second, dialogic engagement is necessary for the assessment of competence in cognitive skills, as well as more general clinical skills, and for the assessment of students' ability to critique their own practices. Importantly, as MacAleer and Hamill recognise, practitioners who have learned their own nursing practice in programmes established predominantly at (higher education's) level one will *not necessarily* take a broader perspective automatically, even with experience, despite the practical problem-solving expertise to be gained as a result of time in practice. Third, if this critical faculty is missing, it is possible that judgements applied by individual practitioners will be informed by their own preferred (i.e. personal) models of practice, rather than by official guidelines, particularly when at least some of the official values – the technical-rational or academic characterisation of practice – are not shared by practitioners (*cf*. UKCC 1999; Payne 1997), and will thus be informed by interests other than those of official intentions.

The research team followed up their study a year later by a series of recommendations for the improvement of practice-based assessment (Phillips *et al* 1994). Based on their findings, the final conclusions highlighted the inevitable intrusion of subjectivity into assessment judgements, and that two assessors are rarely looking for exactly the same thing when judging student

competence. It is recognised that people will always draw on their own experience as well as on official guidelines and assessment schedules in such circumstances. Phillips *et al* acknowledged this as an inherent part of professional judgement, and consequently advocated accepting it, given the context-dependent nature of judgements of appropriate responding in care delivery. To enhance the robustness of judgements multiple sources of subjective perceptions should be accommodated, they suggest. However, this subjectivity applies, it appears, to the interpretation of the givens of assessment documentation only. It does not necessarily allow that, if practitioners have their own internal model of what constitutes acceptable practice in an aspiring nurse, then, regardless of what official requirements stipulate, this may be what leads the judgement. In light of Pask's (1995) study of clinical decision-making, and Fish and Coles' (1998) work on professional judgement (see below) this is more likely to be the case, although it will not actually be recorded. Personal perceptions are unlikely to be exposed to public scrutiny, and so judgements will merely be recorded in language taken from official guidelines, yet actual performance may vary across individuals so described.

Subsequently, Neary has proposed a model of 'responsive assessment' to accommodate the fluid nature of clinical situations, and the dissatisfaction with existing protocols (Neary 2001). Her work spans the 1990s and culminates in this model for assessment, adopting both quantitative and qualitative approaches to data collection and analysis. She contrasts the two approaches by reference to the need to understand problems, not simply provide a tool for testing or prediction. Amongst the findings reported from her earlier work is the

not unpredictable revelation that many practitioners colluded with students in simply ticking boxes to satisfy the training colleges. Outside this requirement, there was evidence that they engaged in some (to them) more meaningful dialogue about actual performance. Hence the students' records had neither validity nor reliability in their application – neither in the conventional sense attaching to positivistic enquiry, nor in terms of, for example, Hammersley's (1989) criteria for qualitative enquiry – despite their being based on explicit outcomes. Students also felt that they encountered a definite discrepancy between "practice reality and college ideals" (p.5), remarkably reminiscent of Melia's (1987) study of occupational socialisation. Unfortunately there is no way of knowing exactly what the content of the unrecorded discussions had been, nor where the discrepancy might come from, other than what are reported as "the use of arbitrary criteria and inappropriate personal opinions" (p.6). An important problem here, not addressed in Neary's paper, is that what constitutes "inappropriate personal opinions" to an uninformed outsider (or perhaps novice) may be a situated and informed judgement to the experienced observer. She rightly points to the control exercised by practitioners over the assessment process and outcomes, but apparently without recognising the influential part played by personal beliefs and values even within a professional context.

That this is influential is demonstrated by Fish and Coles (1998), who explored clinicians' decision-making in relation to clinical actions. They invited qualified experienced practitioners from a variety of clinical backgrounds to explore and write about how they did this. They offer a comparison of the features of what

they describe as the technical-rational and the professional artistry approaches to characterising practice, and point out that technical-rational descriptions (*ergo* competencies as representing this) ignore (hence, dismiss, devalue, exclude) any moral dimension to what is done in practice, or in how judgements are made. They are explicit about the orientation they adopt, rejecting techniques associated with technical rationalism, and adopt what they describe as "critical appreciation" (p.204) as their approach to data analysis. They explicitly reject approaches such as content analysis, frequency counts, theme identification, choosing instead an ethnomethodological approach, to gain an understanding of how their participants use the 'knowledge tools' available to them (Crotty 1998). Their conclusions were in some ways surprising – not least to the participants themselves – inasmuch as their respondents tended to defer to what Fish and Coles call personal theory (amalgams of propositional and experiential understandings) in preference to the formalised, propositional knowledge to which they had been introduced during training. Interestingly, this apparently applied across the group of occupations, regardless of specific professional orientations.

The exploration is interesting and relevant here for other reasons. While nursing practice includes routinised skills and procedures, this is not the totality of its nature. In the context of what has been called new public management, and policies couched in terms of technical-rational accountability and economic efficiency, non-measurable elements will not be counted, since they belong to the domain of professional mystery or mythology. But Fish and Coles make an important point: that simply because, to date, expertise has not been fashioned

in explicit terms, does not mean that it is fictitious. As they comment, it is only relatively recently that practitioners have been called upon to articulate their practices in this manner; failure in doing this may be due to lack of practice rather than absence of knowing.

Another study, from outside the nursing arena, is instructive in understanding how people make judgements about others. Anderson *et al* (2001) used a discursive psychological approach to analysis in an investigation of attributions of blame to rape victims. Their study differed from previous studies of attribution, in that it avoided the simplistic question and answer format associated with this type of investigation. Normally, a brief scenario is presented to individual observers, who are asked to make an assessment of the extent to which one of the characters in the scenario (the victim) is responsible for his/her fate. By contrast, Anderson *et al* suggest that the manner of presentation of questions to be answered potentially limits the range of answers considered possible (or permissible) by the experimental subjects. Their study therefore presented a series of dyads (always male-female) with the same scenario, and asked them to discuss it rather than answer questions, with their discussion (knowingly) being recorded on audio-tape. They were simply asked to try to reach a conclusion about the scenario, rather than to say whether the victim was to blame for the outcome.

Their findings were striking in that participants were found to show a high level of awareness of the fact that the situation had been set up; that it probably had a particular purpose, including to show whether the participants used any

stereotyping, for instance, in their attributions; and that there was a tendency (i) to compare themselves to the person in the scenario, and (ii) to make allowances, by invoking bad luck rather than responsibility, as factors in explaining the outcome. While many of the points derived from conventional attribution theory were present, these were more actively processed than had previously been acknowledged. Thus, what has traditionally been taken as a straightforwardly logical matter of adducing obvious evidence, and drawing uncomplicated conclusions from this in the manner of the naïve scientist, was shown here to be much more sophisticated, and invoked the observer's own interest deliberately prior to stating a conclusion. This understanding concurs with Potter's (1996) explanation of the significance of actors' statements: prior to enunciating any claim or position, actors frequently engage in setting themselves up as innocent of malevolent intent, or as being only inadvertently guilty of such an allegation. In *Representing Reality*, Potter (1996) is concerned to have us understand that individuals are active in constructing themselves as having certain roles, rights, and responsibilities, for instance.

There are two crucial points here, first about how the social world is understood, and second, about how we make decisions in the social world. The modernist assumption that knowledge of the world can be reduced to a set of universal principles, or that a rationalistic form of logic will apply to judgement and decision-making within it, is problematic. It is clear that the subjects of Fish and Coles' study were aware of the formal and the personal versions of knowledge to which they refer in practice. While superficially, and on entry to the study, they stated that they used the theoretical knowledge that was given

to them in training, they eventually came to recognise that they had modified this in the light of their own experience, and now had to accommodate this alongside a more personal understanding. Similarly, Anderson *et al's* study illustrates that how their subjects made their decisions depended to a large extent on who was listening. They were aware of the fact that different possibilities are available, and that there may be some consequence for them – how they would be judged, for instance, by the observer – if they were seen to decide on a particular outcome. Finally, they were mindful of the similarity between themselves and the fictitious person in the given scenarios, and that their judgements might say something about their own culpability or innocence in certain circumstances. Once again Giddens' notion of a practical and a discursive consciousness is useful here, but clearly at the level of *conscious* awareness: different possibilities are available, but are accessed differently according to circumstances.

Another approach to the identification of competence was undertaken by MacAleer and Hamill (1997), who were concerned with teachers' understanding of what they call higher order competence. Their approach differs from most others' in that they recognise at the outset that assessment decisions are necessarily the outcome of a dialogue between the assessor and the student; that is, assessment is a fluid, socially constructed phenomenon. Using tape-recorded individual interviews they set out to engage nurse teachers, rather than clinical practitioners, in a discussion of how they understood what they were looking for, and how this informed their judgement of students. From this

they constructed a text through which they came to understand the teachers' conceptions of assessment in this area.

The authors are careful to point out that higher order competence is concerned with those "features of professional practice which are deemed to be central to the identity of action as nursing action" (p.38), and that this "does not appear to be readily reducible to any single set of tasks or skills" (p.37). They also explain that they

> did not in the first instance endorse any specific definition of the word competence but merely gave recognition to the growing use of the term competence (p.37).

However, although they make explicit the reason for their use of the term, this evades part of the problem. Importantly they fail to consider the possibility that increased use of the term is a central factor in the development of a new discourse of, *ergo* way of thinking about, practice. Foucault (2002a) has shown how hegemonic interests come to be privileged over others through what he calls regularities in the dispersion of statements – key references, similar claims. The regular appearance and adoption of particular terms to characterise ideas builds a dominant view, which legitimises some understandings while de-legitimising others. Curiously, MacAleer and Hamill acknowledge the impact of a changed approach to assessment on future practitioners' understanding of their role, while appearing to acquiesce in the use of this managerialist terminology. Unfortunately, by close association with "the concept of competence in relation to a national framework for vocational qualifications [NVQ]" (p.37) it is difficult to separate their use of the term from the now

common reference to cognitive skills (by implication, therefore, measurable) underlying practice decisions.

They report that their teachers expressed their ideas in language which was significantly different from that used in official documents. Overall their interviewees identified that technical and managerial factors had influenced the way nursing is *undertaken*, but that these were not considered to characterise nursing *practice*. Much of what was said related to the difficulty of describing and assessing its relational aspect. Many made statements implicating a more personal understanding of practice (*cf*. Fish and Coles 1998), and the notion of gut feeling was introduced with reference to the subjective nature of assessment of performance. Their respondents were evidently uncomfortable with this, having apparently accepted the need for objectivity without having identified with it – at least on the basis of their commentaries. They conclude that teachers construed higher order competence as more than cognitive skills, and incorporated a moral dimension into their understanding of practice. They suggest that for this group this kind of competence is “not simply a way of knowing but a way of being” (p.99), implying that whatever is being sought necessarily involves subjective judgement, not merely technical measurement. In this they were uneasy, resulting, the authors suggest, from “a misplaced acceptance of the concept of ‘objectivity’”, linked to “the absence of a fully developed and respected body of language” (p.100), which would enable these teachers to express their judgements in a manner that accords with their understanding of practice, a central issue in the context of my own study.

Chasing rainbows (2): the pursuit of essence

Pursuing an understanding of competence to facilitate its identification and measurement accurately and consistently across situations and people has to be understood as a search for the essence of practice: the pot of gold at the end of the rainbow. Foucault (2002a, b) has criticised the search for essence on the grounds that the continual regression to some notional point of origin is a fruitless task. The process serves to privilege some, and exclude other, versions of knowledge, in favour of those who control its production (Potter 1996). The notion of competence/ies – a reduction to component elements – is privileged in the current discourse of practice. It is presented in the guise of revealing the elements of good practice, but operates through inclusion of the desired (the measurable, e.g. care *delivery*) and exclusion of the undesired (the invisible, e.g. *care*), because, as Potter tells us, such language does certain work for the commentator – in this case, increasing control and predictability. According to Foucault, instead of looking for the essence or point of origin of our understanding,

> We must be ready to receive every moment of discourse in its sudden irruption; in that punctuality in which it appears, and in that temporal dispersion that enables it to be repeated… Discourse must not be referred to the distant presence of the origin, but must be treated as and when it occurs (Foucault, 2002a, p.28).

That is, a particular view arises in its particular time and conditions for particular purposes. I suggest, given the difficulty of definition rehearsed above, that the concept of competence suffers from the same problem. Caring is recognised from within its situated operation, rather than being amenable to reductive analysis; and the same may be true for competence. At best the term

competence in a nursing context remains global, and the term competencies (or competences: McMullan *et al,* 2003) vacillates between the specification of activity or performance (e.g. Cox *et al* 1998) and personal attributes (e.g. IHCD 1998), but always fails in its purpose. Assessment of competence should not, according to published guidelines, become "unduly complex and bureaucratic" but should remain "a reliable measure" (WNB 1997, p.1). However, given the variability in clinical situations it is difficult to see how, without a considerable degree of specification, this aids reliability, unless reliability in turn takes its definition from another source than conventional positivistic reasoning.

One might also ask, if Neary's (2001) "responsive assessment" (p.3) is appropriate, why does it need the concept of competencies? Allowing rather than resisting its entry into our understanding of competent practice merely concedes the territory; allowing practitioners the right to judge according to the situation undermines the (assumed) value of prior prescription, shifting the locus of control away from managers. If nursing activity is to be specified by a series of closely defined competencies, the list is potentially endless – what will be included; what distinguishes nursing from other activities? Since the term cannot adequately be represented in written statements; since each competency cannot be described with sufficient precision to guarantee equivalence between individuals and across situations; since its use within a nurse education context does not accord with the wider discourse of competence (e.g. Jessup 1989) – that is, it does not demonstrate the same degree of precision (*cf*. Winter 1995) – then different interpretations of

acceptable performance, determined according to some other criterion than has so far been assumed, must be allowed.

That the continued pursuit of precise definition in this context is misdirected is well illustrated by Paley (2001). Taking his approach from Foucault's archaeology (Foucault 2002b) he examined a comprehensive bank of literature exploring the idea of caring, generally held to be at the core of nursing practice. For my own purpose, if caring is the core of nursing, then it must be implicated in any discussion of competence. Paley examined the success or otherwise of the numerous endeavours to identify the components of caring, including studies concerned with concept clarification, or practitioners' definitions, for example. The most striking conclusion, unearthed repeatedly in the works reviewed, was the need for further research into the problem! This result, though more frankly stated, does not differ significantly from the findings of more recent publications on competence. Paley argues that the vigour with which the project of clarification has been pursued (*ergo* our ability to specify what exactly we should look for when breaking practice down into its component elements for training purposes) was matched only by its fruitlessness. Thus, any special claim for the nurse to be the carer *par excellence* founders in a sea of uncertainty, so that others can seek to render it more visible, at the same time serving their own interest to gain control of the event.

Chasing rainbows (3): missing the pot of gold

That the problem has lived on throughout the period of the present study is well illustrated in a number of recent publications, including more recent proposals from NMC. A number of authors have confirmed the problem (e.g. Dolan 2003; Watson et al 2002). In a wide-ranging literature review, McMullan *et al* (2003) set out to provide the justification for an ENB commissioned study concerning the development of practice portfolios. These are seen as a way of making competency-based assessment work. Despite this, the authors demonstrate the concept's inappropriateness as a yardstick, given that there is large-scale lack of agreement amongst all who have written about it. Any attempt to capture what is meant by an acceptable standard of practice must, they conclude, necessarily be more than competencies can represent; yet, somewhat bizarrely, they suggest that it be included in any portfolio of work which may subsequently be developed – rather than reject it on the basis of its demonstrated ineptitude. If its nature cannot be defined, its inclusion cannot be any more meaningful than the numerous previous attempts, which have patently failed to solve the problem.

The same point can be taken from other recent work; Dolan (2003) was concerned with assessment of competencies using criteria modified from an earlier assessment tool in a South Wales university. She comments, rather inconsistently with the evidence contained in the body of the paper, that the use of competency-based assessment is "reinforced" by the Peach report (UKCC 1999). This may simply be an unfortunate choice of words, but it would be more

accurate to state that the approach was imposed, despite the evidence available even at the time of publication of the report itself, and that adduced by Dolan, suggesting that agreement on its nature, definition, and implementation is far from established. Again, bizarrely, she proposes that it form an important part of a practice assessment strategy.

Ormrod and Casey (2004) examine the educational preparation of qualified staff for a particular area of practice, and repeatedly refer to the notion of competencies. Their purpose is "to inform the development of a competency framework…", and they include a "review of the nature of competence and some of the different models" available (p.256). Again, they show that there is a general lack of agreement on its meaning; and (inadvertently or otherwise) that the notion is fluid, potentially defined by each individual practitioner (e.g. according to circumstances); and that there is a tendency to vacillate between personal attributes and task-based skills or performance. Interestingly, the uncritical acceptance of prevailing terminology is nicely illustrated in the authors' repeated use of the terms competence and competency/ies interchangeably, apparently assuming the same meaning for both; yet for McMullan *et al* (2003) this is not the case, nor is it for several of the authors reviewed in their own study.

The inadequacy of available definitions and usage of the term competence/ies is summarised by Watson *et al* (2002), who undertook a systematic literature review of work concerned with its definition, clarification, and application. They examined an extensive body of literature, both within and without nursing,

concerning issues such as validity and reliability, content specificity, its distinction from alternative terms such as performance or capability, and its utility in practical application; they found the concept wanting, and their conclusion is unequivocal. While they found some examples of rigour in competency-based assessments, they nonetheless questioned the validity of the approach with respect to everyday nursing practice.

> Nursing, which has adopted a competence-based training system and which has affirmed its affinity for this approach to producing nurses, has apparently learned little from the other areas in which competence has been tried, tested and to a large extent failed. All of the problems of definition, lack of rigour in assessment and tension between competence-based training and other educational approaches are apparent in the nursing literature. (p.429)

It is encouraging to note that, on the face of it at least, NMC (2004) has chosen to replace the terminology of competencies by reference to proficiency; however, a glance at the proposal reveals that only the term has changed. Statements of achievement remain in place, an identical list of pre-determined outcomes. What were previously presented as standards for the achievement of competence are now simply reconvened as standards for proficiency, and the new term serves only to shift attention away from the failure of its predecessor. Regulation remains focused on the endeavour to quantify what has consistently eluded quantification (*cf*. Paley 2001). Changing terminology without changing the way of thinking the event of nursing promotes the political not the professional interest.

More recently NMC (2005) refers to new registrants' level of competence, and is concerned with specific, so far undefined, practical skills, though the search

is on for these. Students' skills "vary considerably depending upon the opportunities they have in training" (*ibid*. p.3), in which case the intention can only be to make *something* explicit, rather than to make the most of individual opportunities in practice, or to capture its complexity. Despite the arguments against it, the search for precision looks set to continue: "clearer expectations […] and more effective assessment of competence may reduce the need for the performance of specific skills…" (*ibid.* p.6); and "by adding detailed competencies to some proficiencies, we can make clearer the level of performance required for safe and effective practice" (*ibid.* p.9). Such claims do not help the problem, as terminology is now thoroughly muddled: skills are separated from competence, yet are surely inherent in competencies; competence is part of proficiency, yet the terms are not distinguished, and outcomes are identical for both. The fruitlessness of the project is shown up. As one of Peach's respondents commented (UKCC 1999), it is inappropriate to define professional work in terms of tasks and procedures.

PROFESSIONALISM AND EXPERT KNOWLEDGE

Changing conceptions

The term professionalism has developed a changed emphasis in recent decades, as demonstrated by Perkin (1989), such that to talk of professionalism now is to talk of how to behave professionally, with practice inscribed in an array of competencies or protocols (Fournier 1999). As indicated above, Nixon *et al* (1997) have written more optimistically of a new form of professionalism,

based explicitly on negotiated, rather than imposed (even if *bona fide*) agreements between practitioner and client, or between practitioners and managers; but this is very different from the historical understanding of the term. This section will highlight some aspects of professionalism, and examine some of the arguments pertaining to conceptions of it.

Freidson (1994) holds that at the core of professional work is a fiduciary relationship with the client, whose interest is held at the centre of practice considerations. By buying into a professional interaction, clients enter a condition of trust – the element notably absent between nurses and their managers, according to Pask (1995) – whereby they defer to the professional's expertise, developed through specialised training, education, and subsequent experience, and which marks him or her out from the client. The claim to specialised knowledge is highlighted by Freidson in *Professional Powers* (Freidson 1986), and much earlier by Etzioni (1969), as key to this understanding of professionalism, bringing with it claims to insights not possessed by the client. It is important to understand that from this perspective professional work is characterised less by references to "tasks and procedures" (a description offered by a NHS manager cited by Peach: UKCC 1999, p. 44) than by claims to expert understanding of problems, hence needs of the client. However, this special status, and its associated autonomy, has become problematic with the rise of the demand for greater accountability. As Ozga (1988) observed, in relation to the work of schoolteachers, changes in policy, while using the rhetoric of greater professionalism, served effectively to increase central (government) control over their work.

Accountability and the requirement to make expert knowledge explicit have rendered the power base of the professions much less unassailable. Claims to specialist knowledge are especially problematic in nursing, since there is no universal agreement on the distinctiveness of nursing knowledge or work. That this trend is not simply limited to the UK (or indeed to nursing education) is illustrated by McWilliam *et al* (1999), who have argued, in relation to Australian HE, that excellence in teaching is being replaced by an emphasis on enterprise and enterprising organisations, such that the excellent academic is the enterprising one, in the sense traditionally associated with corporate business activity. They comment, for instance, that

> The new curriculum for identity formation is…a radical departure from orthodoxy in terms of what knowledge is to be valued, where this knowledge comes from and how this knowledge is to be disseminated (*ibid.*, p.55).

When activities are driven by business values, it is no accident that competencies come to represent practice, in stark contrast with other characterisations of professional or higher education (e.g. Barnett 1995). McWilliam *et al* illustrate the change in the dominant discourse away from client-centred service (in the sense of emancipation in education, caring in health services) in favour of an emphasis on economic and functional values. The shift by government from a position of patron to that of buyer of education's products, with the emphasis on economic efficiency, seeks to reconfigure the nature of the activity of both teachers and healthcare workers. They comment that

> The precise means of doing this is not an open question, but is framed within the dominant rationality for constituting best practice (McWilliam *et al*, 1999, p.61).

This reformulation of professional practice illustrates a particular discourse in construction, the elements of which are identifiable as the frequent and prominent lauding of the visible and the economic; the association of these with the terminology of professionalism; the exclusion of traditional, less easily measured notions of care or emancipation; and the redefinition of these concepts in terms of delivery and measurement. Its intrusion into everyday practice is illustrated by Stronach and colleagues (2002), who have described teachers' and nurses' reported working experiences in terms of a conflict between what they call an ecology – concerns holding priority for practitioners – and an economy – measurability, efficiency, output – of practice. While the latter dominates organisational concerns, the former fits better with practitioners' views of what they are trying to do.

The increasing emphasis on a competency-based version of practice reflects the increasing association of managerialism and professionalism, wherein professional managers can claim expertise in the deployment of resources, human and otherwise, as Perkin (1989) has shown. Two things happen here. First, the close association of terms (manager, professional, effectiveness, efficiency) constructs a discourse of expertise, which omits or plays down less measurable (*ergo* less accountable) elements of practice. Second, the simplification of complex practices by professional managers seeks to make the invisible visible (*cf.* Foucault 1973), allowing greater control and predictability of

individual action, an example of what Strathern (2000) calls the “tyranny of transparency” (p.309).

Predictability and control, then, come to dominate considerations of practice activity in the interest, ostensibly, of consistency and public expectation. A central concern expressed by Peach (UKCC 1999) was the inconsistency, at completion, of programmes from different institutions, despite centrally defined outcomes. Such untidiness is characteristically rejected in rationalist conceptions of the social world, but others (e.g. Usher and Edwards 1994) have argued that variability is not mere untidiness: it is fundamental to human representations of reality. Alternative versions are inevitable, indeed desirable, in the panoply of human experience and action. In nurse education policy, variability is not seen as inevitable, but as inconvenient misunderstanding, or, worse, as non-compliance. In the context of day-to-day practice difference operates as a source of strength (Usher and Edwards 1994), since it acknowledges the contextual dependence of practice, a view which sits more easily with the purpose of nurse educational reform, introduced to produce more critically aware practitioners (*cf*. Barnett 1997; Carr 1995; UKCC 1986).

Thus, the characterisation of practice has become once more dependent on a technical-practical understanding (Milligan 1998; Purdey 1997), based on narrow, static, acontextual ability (Chapman 1999; Wolf 1995). This development uses the rhetoric of professionalism while claiming support from clinical (as opposed to educational) practitioners. According nursing professional status, and appealing to professional standards and performance

in this way, conflates the articulation of nursing knowledge, viewed as an emancipatory project, with the ideology and discourse of reductionist scientific rationality (Francis 2000), which does not sit easily with the situated nature of clinical work.

Nurses' conceptions of professionalism

Conceptions of professional work in nursing vary from the ability to carry out specific procedures efficiently to a concern with shared values and attitudes (Wade 1999; Ohlen and Segesten 1998). For instance, Ohlen and Segesten (1998) explore the notion of professional identity – that is, how do nurses characterise their work and their nursing self – through a comparison of data derived from selected respondents and related literature. Their work focuses on clinical practitioners, and draws out a distinction between values-based views, evidently acquired within an educational setting, and more traditional, task-orientated views which saw nurses as medical assistants, more consistent with practice-as-competencies. The former conception involved characteristics widely supported by others, both within and outside nursing. These include confidence and criticality in pursuing the public interest (Barnett 1997, on higher education); recognition of the need to work with others rather than act territorially (Nixon *et al.* 1997, on teaching; Freidson 1994); mutuality in occupational decision-making (Morrall 1997, on nurse-doctor co-operation); values-based education (Banks 1996, on youth and community education); freedom from externally imposed rules (Davies and Lampel 1998, on further education; Hodkinson and Issitt 1995, on the problem of competencies); and a

high level of specialised education (UKCC 1986, on status and specialist knowledge; Peach 1999).

Wade (1999) undertook an examination of nursing literature focusing on autonomy as a key element of professional practice, premised on a claim to specialist understanding through which it is warranted. While Wade does not offer a detailed insight into her assumptions in this, it is consistent with the historical perspective on professional work, and with the theorising of others (Etzioni 1969; Freidson 1986). Her conclusions bear some comparison with Ohlen and Segesten's study in that discretionary decision-making – freedom to vary decisions according to their reading of the situation – was identified as crucial; but she also found that collegial interdependence (*cf*. Nixon *et al*. 1997, Morrall 1997) and affiliative relationships with clients (*cf*. Freidson 1994, Pask 1995) were important. Wade found that a lesser degree of autonomy was associated with initial training programmes with a practical skills focus – closer to a competency-based approach. It is possible to suggest that if autonomy (as the right to influence practice through negotiation: Nixon *et al*. 1997) is espoused as a professional goal, then nursing must resist a return to skills-dominated programmes, since this reduces autonomy and narrows the definition of practice.

So what's the problem?

Deleuze and Guattari (1994) provide a useful way of thinking about this problem. In *What is Philosophy?* they construct a view of knowledge which distinguishes purely philosophical concepts from their functive counterparts in

the world of science. Philosophical concepts are defined as abstract events, constructions to which we will aspire in understanding the world; these are never true or false, they simply exist as attempts to describe possibilities. By contrast functive concepts have consequences: they are testable against particular criteria; they operate as states of affairs and can be declared true or false. Drummond (2002) provides a pertinent example of this distinction. Citing Paley's (2001) archaeology of caring knowledge he argues that *care*, as the characterisation of nursing, operates at the level of the virtual or philosophical, and defies actualisation. Car*ing*, as its functive counterpart refers to the delivery of procedures, which, as a state of affairs, is measurable. Deleuze's distinction allows us, in this instance, to think the event called nursing, and recognise our practical, empirical, consequential attempts to translate the virtual into a state of affairs.

The problem is that the two – the philosophical concept and the functive – are often conflated. Care, as virtual, releases – deterritorialises in Deleuze and Guattari's (1988) terms – the event from attempts at containment by others – in this instance, by managers, organisations, policy-makers. The tension between these two interests can be understood as

> the plane of a struggle for different ways of thinking the event we call nursing, where *different parties seek to introduce different elements onto the plane of the concept to gain control of that event*. (Drummond 2002, p. 232, emphasis added).

Similarly, competence, understood as a global concept, a virtual through which we try to think the event of (acceptable) nursing practice, is subject to a struggle for control. Attempting to make explicit the kind of thing to be sought is not the

same as following a prior specification of what is assumed to be there. The one looks for evidence of a type; the other asks whether *x* has been found, not something of the type *x*.

CONCLUSION

The concept of competence is at best contested. Its value as evidence of safe practice is spurious, since it fails to capture complexity in an integrated form: isolated procedural performance cannot equate to judgement or generalised capability. It has become strongly associated with notions of measurement, through a shift in the discourse of professional practice; at worst it misrepresents a complex, situated practice. As Foucault (2002a) would have us understand, such a discourse is an irruption of its time and circumstances. It seeks to reduce difference and operates in others' interest. Measurability masquerading as professionalism is a function of its time, intended to render control to others. Hence, as a means to capture the detail of practice the concept is rejected as having no worthwhile substance; analysts and policy-makers have sought to give it substance, but nothing appears to stick. Consequently, it fits better with Deleuze's notion of a virtual: a concept on a plane of immanence, with an indefinite number of elements attaching to it to give it its consistency. It remains something to which people aspire without ever being able completely to actualise it in a state of affairs (Drummond 2002; Deleuze and Guattari 1994, 1988).

Conceptions of nursing practice vary too much to be adequately captured by competency-based models. Policy-makers and the managerial interest have

simply sought to territorialize the field to which it belongs, in order to convert it to a functive. In the process something has gone missing. All attempts to define competence/ies on behalf of policy, and to redefine the nature of professional practice, have failed to provide the clarity desired despite increases in their detail (*cf.* Paley 2001; Wolf 1995; Hodkinson and Issitt 1995). Paradoxically nurses are trained to care for people in vulnerable situations involving complex judgements (UKCC 1999), yet there is a lack of trust in their ability to judge students' actions *in situ*: in how they deploy what they know, or how they extend and develop it. Concern with accountability and measurability, the redefining of professionalism (Nixon *et al* 1997; Perkin 1989; Ozga 1988), and inscriptions of professional behaviour in competency statements (Fournier 1999) seem only to have placed limitations on the identity of nurses and nursing.

The absence of an articulated body of distinctive knowledge to which nursing can lay claim makes it easier for the concept of nursing to be defined by others, though this does not mean that this will be owned by individual practitioners. As Drummond (2002) has argued, attempts to define precisely the concept of care as the core of practice treats it as a functive rather than a virtual concept (Deleuze and Guattari 1994). Similarly, using competence as a functive concept limits its potential. Rejecting the reductionist approach to the ascription of acceptability to students' practice means that we can ask instead how practitioners make sense of the situation (*cf*. St Clair 1997). The issue is then how they constitute themselves as nurses, and thus what they look for in others.

Recognising the relationships of power, authority, and control between nurses and their managers, their employing organisations, and their governing bodies – hence with teachers as trainers – what is said may, in the end, be only that: what is *said* about assessment practices. This research will ask practitioners to talk about, and illustrate from experience, how they make their decisions on acceptability; it will not look for yet another definition of competence in practice. The study seeks to expose practitioners' criteria for ascribing acceptability, why these are considered important, and how they are applied or varied, without reference to externally defined options. From this it is intended to explore how they use what they know; how they think what they do, what sense of identity they hold as nurses; and from this whence assessment of practice may be led to enjoy a greater sense of ownership than appears to be the case currently. Why and how alternative criteria may be used will be important for two reasons. First, since assessors are situated in the world within which future registrants will be required to practise, they may be locked into a particular perspective on it (*cf*. Carr 1995). Second, given the balance of power in nursing, justifications at this level can be dismissed as simply misinformed: in light of the difficulties rehearsed above official versions of competence may, in the end, be both impracticable for and alien to practitioners.

Chapter 3: Theoretical Orientation and Methodology

This study grew from the idea that, whatever practitioners were doing when assessing students, it did not seem to be entirely based on the given notion of competencies. Sometimes apparently very capable students would receive poor practice reports, while others, apparently less able, would receive very positive reports. Previous attempts to understand and subsequently address the problem of apparent inconsistencies in assessment have generally focused on structural factors as barriers to the implementation of given protocols. These have included organisational demands, pressures, and constraints on practitioners, insufficient clarity in the definition of outcomes provided by educational institutions, or inadequate preparation of practitioners for the role, for example. Accordingly I had thought it would be useful to obtain a clearer understanding of how practitioners themselves defined competence, since definitions to date were driven predominantly by policy or professional gatekeepers. From this it might be possible to develop a better definition of the competencies everyone was looking for, which could be incorporated in assessment documents. However, as Chapter 2 has illustrated, a unifying definition of this kind is extremely problematic; attempts at clarification have conspicuously failed to provide an effective remedy. Additionally, as the difficulties identified to date imply, nursing is a socially situated practice, and

thus necessarily subject to different influences and interests, and resisting a singular construction of its working.

These considerations led me to an approach which foregrounds localised understanding, and allows for differences in the way practitioners identify and use their knowledge. This is not to imply a chronic indecision in the assessment process, but rather to allow that there may be different versions of knowledge and understanding operating according to context. As Andersen (2003) has observed, such differences may form a relatively orderly pattern, with the important caveat that order should not be conflated with unity. The concept of competence as a focus for the study was rejected in favour of the notion of acceptability, implying a more open judgement, and leading to a more open form of question: what account do practitioners give of acceptability in practice; how do they account for any variations? This revised approach will be outlined below, along with key points from theories informing the analysis as it developed.

PURPOSE OF THE STUDY

In summary I set out to try to understand how practitioners accounted for their decisions about students' practice development – why the situation is as it is for them (St Clair 1997) – and what this might say about their position *vis-à-vis* nursing practice. Associated with this were questions of how they saw themselves as nurses; what sense of identity did they claim; how did they position themselves within the prevailing discourse of practice, and the associated power relations? I do not claim to have revealed some fundamental,

phenomenological essence of practice for these practitioners (Johnson 1997; Crotty 1996). Instead, what is presented is an account of how they constructed their own discourse, accessing different reference points when making judgements, constructing and reconstructing themselves according to the demands of changing circumstances. In short, the approach to data collection and analysis developed to allow that they operated within their own localised understanding of nursing practice. This was achieved through an examination of their accounts of the decision-making processes involved, which revealed differences between the public discourse of nursing and the private practices of its members.

THEORETICAL ORIENTATION AND ANALYSIS: AN OVERVIEW

It is recognised that assumptions about the nature of the knowledge sought will influence the formulation of explanations (e.g. Huberman and Miles 1998). Having embarked on the study with the idea that practitioners' definition of competence/ies may simply be more useful than formalised versions, this was found to be too positivistic, in that it anticipated a concept that could be circumscribed. While the initial analysis drew on correspondence and attribution theory (Jones and Davies 1965), as though a straightforward process was operating, the discourse analytic perspective adopted subsequently (Anderson *et al* 2001; Edwards and Potter 1995) showed that practitioners' attributions served as a means of articulating their understanding of practice, of themselves as nurses, and also as a form of self-defence (Foucault 2000, 2002a). Additionally, it revealed what was often experienced as the impossibility of decision-making (Derrida 1995). I came to understand that the way practitioners

determined students' acceptability, whilst initially appearing as a rational process, was not a fixed entity in all situations, nor indeed the same entity for all practitioners: any pattern identified would not necessarily hold for all individuals or all situations. Their fluid accounts of knowledge and understanding could be understood by reference to the ideas of Deleuze and Guattari (1988, 1994; Deleuze 1994). Practitioners and students operate in varying settings; hence, they may interact with local conditions in ways which differentiate their actions from others' while maintaining a professionally appropriate approach. Each of these aspects will be considered further in the following sections.

To assume that the problem of assessment lies in practitioners' ability to make appropriate judgements implies that practitioners do not understand the nature of practice, despite their immersion in it. Similarly, to assume that the problem lies in the way criteria are presented implies both that practitioners are not capable of recognising increasingly explicit guidelines, and that more detailed written criteria will identify the essence of what is sought. Unfortunately, neither of these options questions the legitimacy of what is written. Even where recommendations have moved towards a dialogical basis for assessment (e.g. Neary 2001; MacAleer and Hamill 1997; Phillips *et al* 1994), the focus of dialogue is always ultimately some definable notion of competence/ies to be adopted by all. However, given the variability of student-practitioner encounters, combined with the problems identified in the last chapter, a third possibility is thrown up: that the problem lies in the assumptions behind standardised statements in assessment protocols. The source of difficulty may be misattributed, and different understandings of practice knowledge may be

operating. At the very least there may be factors not so far accounted for which influence practitioners' ascriptions of acceptability. What matters then is how they account for their practices, not a search for a fundamental essence.

A dynamic analysis

In the spirit characterised by Schatzman and Strauss (1973) I wanted an open stance to whatever data might arise, in trying to understand how practitioners made sense of, or accounted for, their practices (St Clair 1997). Stronach and MacLure's (1998) analogy of surfaces folded in on themselves proved useful in thinking about this: a continuous surface – smoothly connected reasoning, for instance – is often apparent, yet closer examination reveals elements normally hidden from view, so that the eventual understanding becomes less obvious. In my analysis the initial use of attribution theory revealed what might be seen as the smooth surface; subsequent analysis revealed the folds and concealed aspects of participants' stories.

As Strauss and Corbin (1990) and Schatzman and Strauss (1973) point out, choices at the various stages of analysis are the researcher's – my – own, based on interpretation of the similarities, differences, and apparent significance of elements as they were presented by participants. Given the fluid world of clinical practice it was important to allow for the possibility that unexpected or inconvenient elements may emerge. Thus, the generalising tendency was reversed: such responses were held to be offering something alternative, but no less legitimate for that. Alvesson and Sköldberg (2000) observe that in analysis there is a tendency to assume that elements falling

outside the predominant pattern are considered ‘not cases’ (or at least not typical) of what is sought. In Western thinking patterning is often accompanied by the examination of atypical examples of data to explain their (temporary) non-fit with the dominant pattern. This relegates potentially legitimate knowledge claims to inferior significance, simply on the basis that they are different. Such a tendency was initially evident in my own analysis: a focus on apparently privileged criteria, and their linking together as relatively discrete categories. Subsequent re-focusing led me to see such elements as examples of particular interpretations for particular practitioners usually for particular circumstances.

Furthermore, researcher-as-insider assumptions about practitioners’ activities in assessment provided a source of potential bias (*cf.* Goodman 1998). Because the enquiry was based on the assumption that practitioners may not be doing what official directives require them to do, the questioning style may have shown weaknesses not immediately evident in the process of interviewing. To help overcome this all interviews were transcribed personally to encourage a better appreciation of the nuances of participants’ meaning and implications (Fish and Coles 1998; Huberman and Miles 1998). However, Denscombe (1998) usefully distinguishes an open mind from a blank mind, implying that there is considerable background psychological noise at work. As issues of interest appeared in participants’ responses, clarification was sought there and then. Again, these decisions were my choice as researcher, based on the perception of something as interesting (to me), rather than on the assumption that those elements were inherent in some immutable definition of assessment.

Initially practitioners' accounts, in which they appeared to access a particular model of the good nurse, could be explained by reference to theories of attribution and correspondence (Kelley 1967; Jones and Davies 1965). Viewed retrospectively, this assumed that these would be static and discretely held; but it subsequently became apparent that practitioners had an interest in utilising a certain kind of criteria, a point not entirely evident from the more traditional attribution analysis. Thus, it was more useful to take a discourse analytic approach to participants' explanations (Anderson *et al* 2001; Edwards and Potter 1995).

Later again practitioners' identification with different, frequently competing, and potentially incommensurate, understandings of practice emerged. They appeared to construct their own discourse (Foucault 2002a), and engaged in what Foucault (1977b) refers to as transgression when articulating their understanding. Foucault's approach to self-constitution (Foucault 2000; Rabinow 1984) was drawn on in looking at how practitioners constructed their professional selves – what it means to claim to be a nurse – from within this discourse. Deleuze and Guattari's ideas on the nature of knowledge, and their distinction between philosophical and functive concepts (Drummond 2002; Deleuze and Guattari 1994), were also helpful here. Consequently, the profound difficulty of the task at hand – making decisions about students' performances – was revealed when practitioners encountered conflict between the general rule and the particular situation or student, and Derrida's notion of undecidability and justice (Derrida 1995; Edgoose 2001) was utilised in

examining this. More will be said below about each of the approaches and their relevance to the study.

ATTRIBUTION AND CORRESPONDENCE

The analysis commenced with a search for the kind of concepts or criteria accessed as characteristic of an acceptable level of student performance, following broadly the model of content analysis described by Miles and Huberman (1994). In the very early stages this proceeded *as though* decisions about student performance were a straightforward matter, untouched by any personal or contextual agenda on the part of the participant. While this initially seemed to point to the kind of criteria accessed by individual practitioners, I rapidly came to view it as an inappropriately low level of analysis: it simply provided a list of things sought as discrete entities, without reference to why they might be included. What was needed was a means of understanding how they were utilised or varied. Miles and Huberman's illustration of the technique lists some 300 identified items from one of their own studies. These elements are subsequently re-formulated into a series of broader categories, as related elements in a patterned whole. In the context of my own study, this technique presented an unacceptable paradox: in seeking to understand how practitioners accounted for what is regarded as a complex and integrated process, its reduction to elements isolated from the context in which they are found seemed to miss the point. Whether practitioners actually use these elements is always a moot point; what was held as important was how practitioners accounted for their deployment of such criteria in dealing with complex problems.

It became evident that practitioners were pointing to the dispositional qualities of the student. It was therefore more useful, in explaining this process, to make reference to theories of attribution and correspondence (Kelley 1967; Jones and Davies 1965). Attribution theory developed from Heider's (1958) work in social perception. He proposed a set of rules by which ordinary people attribute responsibility to another person for an observed action. Characterised as naïve or lay psychology this was subsequently re-worked by Jones and Davies (1965) and Kelley (1967). Heider distinguished between internal and external causes of actions; both personal and environmental factors are influential, and the balance of these leads observers to attribute the cause of an action to the individual or to the situation. Kelley (1967) further developed the theory, hypothesising other factors that affect the formation of attributions: consistency, distinctiveness, and consensus. Jones and Davies (1965) sought to strengthen it through their theory of correspondence: the degree of match between choices and available options, actions, outcomes, and dispositions, and it is this development that was relevant here.

Jones and Davies argue that when an action is out of role, or expectation (e.g. when a student nurse adopts what is viewed as disinterested behaviour *vis-à-vis* learning about nursing), it is more likely that this corresponds to a personal disposition than to role-consistent behaviour. It is to be expected that a student nurse would take steps to pursue understanding, skills development, or to demonstrate an interest in people. In this situation the display of such highly approved actions would not tell much about the individual, since they are explained by reference directly to the role's norms. In short, 'S/he *would* do that,

wouldn't s/he?' However, where apparent *dis*interest is displayed, the perceiver has to take account of other possible explanations, prior to applying an unfavourable judgement about the individual's practice. Otherwise such attributions may be deemed unfair or unwarranted. Non-favourable actions – by implication, non-favourable dispositions – bring about what Jones and Davies (1965) refer to as non-common effects, and thus would seem to have more personal meaning if they are undertaken deliberately. This is especially relevant in the context of this study, since unfavourable judgements of development may affect continuation on the training programme. Only when alternative explanations – clinical, educational, or personal – are found unsatisfactory is a final judgement applied.

Such reference points as emerged from this approach led briefly to consideration of the possibility of sorting criteria into a number of (fairly discrete) categories, characteristic of the rationalistic assumptions of traditional attribution analysis. However, sorting and categorising became problematic, since elements were used in combination and not always consistently, and so did not fit discrete categories. Thus a greater complexity than had been assumed was revealed. While initially there appeared to be an order of priority in the criteria cited, it became evident even at this stage that there was some variability in this ordering between participants and between the situations they described. The problem of categorising elements gave a new, continuously developing direction to my approach to the data.

Attribution: rationalistic ascription *vs* deliberative pronouncement

Attribution theory has been criticised latterly for its failure to take into account the possibility that individual actors, as observers of others' behaviours, may engage in a more active process than originally thought (Potter and Wetherell 1987). Typically, experiments illustrating attribution theory have involved a number of subjects being asked to ascribe responsibility for a given set of events, commonly presented as a scripted scenario accompanied by a set of predetermined questions. The outcome of this design was taken to demonstrate a system of causal attribution, in which someone was judged responsible for a set of events, based on balance of probability that any discrepancies between what was expected and what was found must be attributable to an individual quality.

However, it is now held, as Anderson *et al* (2001) and Edwards and Potter (1995) have shown, that this work failed to take into account the possibility that people operate as knowledgeable agents. Hence, any conclusions expressed by individual subjects are likely to be at least influenced, if not determined, by their pre-existing understanding of what is going on, by the conditions under which they are reporting their findings, and by the similarity between the situation described and their own circumstances. Potter and a number of his co-workers (e.g. Edwards and Potter 1995; Potter and Wetherell 1987) have been particularly vehement in this respect. Potter argues that it is important to look at what work is being done by particular formulations when statements are made; individuals do not simply report what is there, but will actively position

themselves in any given storyline. The relevance of this understanding to my own study arises from just these considerations: participants' awareness of their situation in the research process; their relationship with students undergoing assessment; their place in the education and training project overall; and the implications of their judgements for their own status as competent practitioners. This more interest-laden perspective, contrasting with the assumption that some fixed truth is being sought, informed the next phase of the analysis, and anticipated the subsequent discourse analytic approach.

LOCAL VS. UNIVERSAL KNOWLEDGE

It is characteristic of a rationalistic view of the world that entities are identifiable, controllable, and essentially the same regardless of time and place (Wainwright 1997), or can be developed to be so. Untidiness, ambiguity, or potential randomness are not well tolerated in rationalist conceptions of the social world, and are characteristically rejected in favour of clarity (Bauman 1995). Current policy in nurse education has promoted such an approach to characterising practice, but this approach necessarily assumes – or, more accurately, claims – that assessment is a rational process, or can be devised as such, as though situations and the people in them remain constant. The degree of variability in practitioner judgements does not convincingly support this view. Practitioners are knowledgeable actors in their world, and necessarily, either individually or collectively, already have an understanding of what constitutes a claim to acceptable practice (Fish and Coles 1998).

One of the core ideas in Giddens' (1984) theory of structuration, in which he argues for the interdependence of structure and agency, may throw some light on the problem. Giddens argues that individuals act with a certain knowledge of situations by virtue of their intimate engagement with and experience of them, an idea borrowed and adapted from psychoanalytic theory. This form of knowledge, referred to as practical consciousness, is said to operate at a level which is not necessarily available to full awareness: it is the resource that people call on to make sense of, and solve, day-to-day problems. However, individuals also have access to what he refers to as discursive consciousness: what is known by individuals about what they *ought* to say or do, that is, where the contemporary discourse of social life lies. Individuals negotiate between these two understandings when called on to decide how to respond to a given situation; and importantly, Giddens proposes that such a condition does not dictate action, but merely influences it. There are striking similarities between this view and the situation facing practitioners in the assessment process. Similarly, Pask's (1995) study showed that practitioners access both types of awareness in their day-to-day clinical decision-making.

Suspicion of the application of fixed, universal rules to determine or explain social action is a central feature of postmodernism, and I have subsequently adopted this stance in examining practitioners' assessment decisions. Derrida, for instance, encourages us to look beyond what is said or written, to uncover what is not said, with respect to claims for what counts as knowledge (Derrida and Caputo 1997). Though speaking in the following comment about the

concept of deconstruction, his point can be applied to the postmodern perspective generally; what gives it its moment is

> … constantly to suspect, to criticize, the given determinations of culture, of institutions, of legal systems, not in order to destroy them or simply to cancel them, but to be just with justice, to respect this relation to the other as justice. (*ibid*., p.18)

An important point here is that he is concerned "to be just with justice", that is, to avoid or overturn attempts artificially, or in the interest of others, to exclude certain troublesome (though nevertheless legitimate) possibilities. The key thing in this definition is to "suspect, to criticize, the given determinations…". It became clear as I developed the analysis that judgements are made by *particular people* in *particular situations*, and are not necessarily governed by the "given determinations" of assessment protocols. Different individuals may have different ways of understanding their situations. St Clair (1997) captures the point nicely when he comments that what is needed is

> … [to] be open to understanding why the whole situation is the way that it is. In what way is it understood by those people who participate in the situation every day, and how do they make sense of it? (p.398).

Francis (1999, 2000) makes a similar point, when she argues that the nursing project takes a largely modernist approach to knowledge, inasmuch as it is searching for rationalist and essentialising explanations of nursing issues (*cf.* Paley 2001 on the concept of caring). She suggests that postmodernism and nursing research are therefore "uncomfortable bedfellows" (p.20), but makes the useful point that, while a postmodern approach may offer no immediate alternative, it seeks to expose the non-rationalistic nature of such practice, and thus encourages the researcher to look into the meanings of practices and

claims to knowledge. As chapter two has shown, practitioners vary in their approaches to assessment; the analysis offered here will move beyond a rationalist conception of assessment practices, but does not try to define the absolute essence of what is sought.

Discourse *vs.* essence

Discourse, in contrast to the search for essence, is predicated on acceptance of "anti-essentialism and indeterminacy" (McAnulla 1998, p.6). It is concerned with things said, done, included or excluded in the expression of ideas, so that privileged status as knowledge or truth can be claimed for some, while others lose legitimacy as topics for debate. In *The Archaeology of Knowledge* Foucault (2002a) has shown how hegemonic interests come to be privileged over others through the formation of discourses, which legitimise some understandings while de-legitimising others. The shift to competencies in policy provides an example of this, raising the possibility that practitioners' own understanding becomes marginalised.

Foucault wants us to understand that discourses are formed through regularities in the dispersion of statements. This does not say that the same terms are always used, but that particular understandings are implied and promoted – here, notions of visibility and measurability, for instance. His analysis demonstrates an enunciative function, in which the warrant for particular claims is established, not following rationalistic, reductive analysis, but as a result of particular interests coming to the fore – the need for predictability and control in managing nursing, for example. Control over the

means of dissemination by powerful groups (e.g. policy-makers) then allows particular views to be sustained, while others are excluded, played down, so that an interested view comes to dominate thinking. Foucault comments that "the manifest discourse, therefore, is really no more that the repressive presence of what it does not say…" (Foucault 2002a, p.28). The "repressive presence" of things not said is understood as a deliberate exclusion, or underplaying, of one way of thinking in favour of another, preferred and determined by powerful others. For nursing, there is a tension between the interest of those who would control and direct practice and the interest of those who are immersed in it from day to day (Drummond 2002; Fish and Coles 1998; Payne 1997; White 1986).

Thus, discourse implies a struggle for influence, involving competing strategies (Heiskala 2001) and reference points in the expression of knowledge (Deleuze and Guattari 1994). This struggle implicates a conception of power distinguished from power as a possession of one party wielded over the other (Hindess 1996; Foucault 1980). Although nursing appears to operate with the latter version, Foucault's alternative conception provides a less sterile understanding of practices in context. He has it that power is a productive rather than oppressive force, and so we might understand it as the energy of the struggle between those involved. Indeed, he distinguishes power from domination – the absence of freedom to resist – a sterile and unproductive condition, limiting the creative possibilities of human activity. Chapter two showed that attempts to control practitioners' decision-making in assessment have patently failed. This may be explained by reference to lack of clarity in the

rules to be applied; but I want to suggest that it may be seen as an attempt to influence outcomes, through a covert form of action in response to the impositions of powerful others.

Heiskala (2001) provides a useful account of this view of power, outlined in the last chapter, for the present study. The notion of a strategic analysis of the presenting problem can be seen as the difference between what the practitioner sees, and what s/he is *expected* to see. Constraints on action can be found in the form of nursing's regulatory norms to be followed, or in the fear of sanctions which can be applied. Relations are clearly institutionalised and rationalised: in nursing these have traditionally been hierarchically sanctioned. There is always the option, at the level of individual practice if nowhere else, to resist the desires of the other, though there may be sanctions if this shows (public) non-compliance (*cf*. Pask 1995).

Crucially, for Foucault, this more productive understanding of power presumes resistance (Foucault 2002a), created by the presence of different interests. Practitioners are concerned with situated problems in the here and now, while powerful others want to control, predict, and direct action. Where individuals resist the prevailing discourse – where they choose to vary from it, as shown in the variability of their assessments discussed in chapter two – this may be understood as what Foucault (1977b) calls transgression. That is, they are pushing at the edge of what is discursively permitted, testing the boundaries of accepted knowledge. However, Foucault also tells us that when the boundary has been breached, we are keen to return within it, since the territory outside is

uncertain ground. Thus, we appear to acquiesce to the dominant view, and come to occupy a space close to the edge. My analysis will show practitioners performing in this territory.

Competing for the plane of practice

While hegemonic interest, then, comes to determine what counts, at least publicly, as knowledge, this does not mean that more than one version of knowledge will not operate in practice. Foucault tells us (Andersen 2003; Foucault 2002a) that more than one discourse is possible; indeed, several may run in parallel. A technical-rational discourse does certain work for the managerial interest, in the context of accountability and cost-efficiency; but it does not necessarily describe the practice that practitioners, privately, might claim or carry out. My study will show how these practitioners dealt with this problem.

Deleuze and Guattari (1994, 1988) also argue against the validity of a singular way of thinking and being, also concerned that this limits rather than aids human possibilities. They argue that knowledge occupies a plane, an always expanding space containing all related possibilities in a field of understanding, not arranged hierarchically, but with each element connected to every other, and always available for selection according to particular situations (Deleuze and Guattari 1994; Drummond 2002). In their understanding knowledge forms rhizomes: that is, aspects or elements of knowledge reappear over time and space, apparently new, but always connected. Deleuze applied this idea to

Foucault's work, suggesting that knowledge develops along lines of flight, whereby

> thinkers are always, so to speak, shooting arrows into the air, and other thinkers pick them up and shoot them in another direction (cited by Katz 2001, p.117).

The arrow has the same origin, hence the same idea is involved, but is adapted, viewed from another angle to look different, and is put to different use.

Deleuze and Guattari (1988) talk of planes being "territorialized" (*sic*) by others – that is, concepts can be captured, redefined, and put to work for purposes other than those to which they more naturally belong. They provide an extensive critique of the way in which modernism has sought to impose a singular view of knowledge and practice, and so deny legitimate, creative difference. This, they argue, leads to an impoverishment of human potential and action, by removing difference, hence creativity, and constrains everyone to an artificial show of unity. From this perspective, policy can be said to have appropriated, or territorialized, the plane of practice for managerialist purposes. I will show in my analysis how practitioners dealt with the differing elements on the plane as they saw it.

Deleuze and Guattari make another helpful point for examining the data in this study, when they propose that concepts exist at two levels, virtual and actual (Drummond 2002; Deleuze and Guattari 1994). The virtual operates at the pure philosophical level, being something to which we aspire; as such it is neither true nor false, but simply is. The actual exists as what they call a functive, and

is an attempt to translate ideas into reality, into a state of affairs. As such they can be measured, taken as true or false, concretised. The problem, they explain, is that the two are conflated and dealt with as though they are the same. I want to suggest that the notion of competence is a virtual, to which nurses aspire; its functive counterpart, competency, is a flawed attempt to actualise this (*cf*. Drummond 2002), but has been conflated with the former. The extensive evidence of inconsistency in assessment to date lends support to this understanding. Hence, we have a useful way of thinking about the problem, and the tension between the practitioner and the managerialist interest can be understood as

> the plane of a struggle for different ways of thinking the event we call nursing, where different parties seek to introduce different elements onto the plane of the concept to gain control of that event. (*ibid.* p. 232).

Attempting to make explicit the *kind* of thing to be sought is not the same as following a prior specification of what is assumed to be there. The one looks for evidence of a type; the other asks whether *x* has been found, not something of the *type x*.

DISCOURSE AND PRACTICE KNOWLEDGE

I have argued that practitioners operate within a culture of surveillance (Pask 1995), and that they are resistant to the formalisation of knowledge for practice (Stronach *et al* 2002; Payne 1997; White 1986). It is possible, therefore, that two versions of practice operate in parallel, the publicly acknowledged managerialist version and the privately held practitioner version. In exploring this I have made use of Potter's (1996, 1997) and Anderson *et al*'s (2001)

discursive analytic approach to things said. This moves beyond the assumption that statements are mere representation of fact, and combines well with Foucault's approach to discourse in the wider context (Foucault 2002a). Where limits are imposed on the expression of knowledge, Foucault argues that these are in the interest of powerful or influential groups, and arise from a combination of power interests and conditions prevailing at any given time.

His point is that the dominant way of looking at the world is a product of its time and circumstances, rather than the linear, logical development from some preceding phenomenon. Thus, no single version of knowledge is necessarily more valid than another. He offers two linked approaches, archaeology and genealogy, in establishing the development of the prevailing discourse. Archaeology looks for the regularities in the dispersion of statements, the key characteristic of discourse (Foucault 2002a); genealogy looks for the conditions which lead to or permit the formation, and maintenance or discontinuity, of particular versions of knowledge (Andersen 2003). This means the presence of discourse(s) can be revealed: what is said and by whom; using what reference points; for what purpose; under what combination of conditions?

I have argued that policy makers have appropriated the understanding of what counts as practice knowledge, and lauded a version of professional practice according to managerialist priorities. I will show how practitioners in this study dealt with the prevailing discourse, and countered this with their own, through the regularity of their own statements about what counts and why. While the legitimate interest of less powerful individuals is, at best, played down by the

more influential strategy of managers and policy-makers (Heiskala 2001), participants developed an interesting strategy through which to retain it. This jostling is captured in the notion of power relations, illustrated earlier – the strategic struggle for influence. On this account compliance with a standardised approach to reporting acceptability will be seen merely to disguise the content of, rather than represent, private judgements.

CONSTRUCTING IDENTITIES

It became evident through the process of interviewing that participants in the study were constructing themselves as they had not done previously. In order to understand this aspect of the data, I have drawn on Foucault's writings on the constitution of the self. His early work focuses on discursive and disciplinary mechanisms determined by powerful figures or organisations as a means of defining the individual (Foucault 1977a). His analysis shows how, over time, the specification of how to behave in different settings became more and more specific; individuals were encouraged to internalise and adhere to prescribed procedures, in order to obtain approval. The production of competency statements has an obvious parallel with this, as shown in Fournier's (1999) study.

Lorentzon (1990) has drawn attention to the centrality of internalisation in contemporary training practices in health care and education occupations. The outcome of the process is that individuals will become good nurses or teachers as defined by others, acting to the benefit of the social manager to reduce variability, difference, unpredictability, randomness (Bauman 1995). Thus, such

specifications implicate characterisations of a given discipline, influenced by the power relations to be found in it. As will be discussed below, some authors, e.g. Giddens (1984), have criticised Foucault's use of the prison or the military to illustrate and support his argument, implying that limitations on certain actions are legitimate, since they follow from certain legitimate life choices, whereas entry into prison is not. However, Bauman counters this by explaining that, while Bentham's intention as a reformer was the better integration of individuals into society, achieved through his model prison design, Foucault's use of the image simply draws attention to its potential as a means of social control. In this case it operates in the interest of the powerful other, denying the individual full freedom to be or become him or herself.

One consequence of such a process is that it produces resistance – overt compliance for fear of punitive sanctions, but without internalisation (*cf*. Pask 1995) – and attempts subsequently to circumvent the required response. Somewhat to my own surprise practitioners in this study showed reluctance to align themselves with the technical-rational model of practice, moving to and fro at the boundary between the official view and their own understanding of what it means to be a nurse. They seemed to want to identify a space in which they could exercise freedom, resist or influence the dominant view, and write themselves differently. However, as will be shown, the discomfort produced by this activity led many frequently to turn back to the discursively permitted. Practitioners – as other individuals – experienced considerable uncertainty once they move outside defined territory, since there was nowhere familiar to move into.

Foucault replaces his earlier disciplinary approach to self-constitution, criticised as too structurally driven, in his later work when he talks about the process of ascesis, self-writing, which arises from self-examination (Foucault 2000). While societal prescription seeks to define and contain the individual, the process of ascesis is central to individuals' own self-determination in Foucault's argument, since it reveals to the individual what, how, and why s/he thinks or acts as s/he does. The process of interviewing, with questions posed to clarify practitioners' understandings of what they were doing, had marked similarities with this process: many participants commented that they had not previously indulged in this act of self-writing. As a result individuals determine their own identity – or identities, since the notion of a singular self, unvarying, unchanging, enduring regardless of circumstances, is untenable for Foucault. An important aspect of ascesis is that it resists a fixed or singular version of the self. Indeed, any attempts to pigeonhole participants' statements were resisted during the interviews, although it has to be acknowledged that this may simply have been a performance for the researcher as audience; I could not ignore the possibility that each interview was perceived as an encounter between potentially conflicting interests, and for each, I posed the initial questions.

This more mobile view resonates with Deleuze and Guattari's (1988, 1994) perspective on knowledge planes and conceptions of self as more fluid than is permitted by static models. For them, self is always in a state of becoming other than it is now. To impose a singular identity is to limit the possibilities for humankind; in effect this is no more than a form of domination – there is no pre-

given self. In this respect Scott (1990) usefully points out that Foucault avoids references to any notion of liberation from the domination of others, on the grounds that that would imply a pre-given concept of self, to which the individual returns once freed from the constraints of power-invested relations. This would run counter to his own argument: self is formed and re-formed more or less constantly through the struggles encountered in everyday life. Scott records Foucault's view that freedom "is found in part as the historical and optional development of self-constitution" (*ibid.* p.91). My analysis will show how practitioners constructed a fluid self, orientated to the particularity of the situation (Derrida 1995). Further, it will draw out a counter-discourse of practice mobilised in the search for evidence of acceptability. I will show how practitioners, through their multiple nursing selves, sought to position themselves in relation to the official discourse.

DECISION-MAKING

A central problem for assessors is to ensure that criteria are applied fairly and equitably across the student population: judgements are intended as equivalent and constant regardless of time or place (*cf*. Edgoose 2001). For Derrida, there is an ever-present problem here. To make a decision based on judgement is not merely to apply some given principle mechanistically (Reynolds 2001; Derrida and Caputo 1997; Derrida 1995); this would be mere computation, not judgement, or, for Derrida, a genuine decision. The particular nature of the situation leads to a problem within which, as Reynolds puts it, "the demands of the singular other … are importantly distinct from the ethical demands of our society" (Reynolds 2001, p.39). Derrida points to the dilemma that to be just to

the other in this situation may conflict with justice to *all* others who are implicated in the same general principle. It is a consideration of the distance between conditions of mere conformity and the particularity of a given situation that creates both the problem and the possibility of a *just* decision (Derrida 1995). The problem arises in part because of the face-to-face encounter involved in this kind of relationship (Edgoose 2001; Reynolds 2001), and the responsibility which arises from this.

> As soon as I enter into a relation with the other, with the gaze, look, request, love, command, or call of the other, I know that I can respond only by sacrificing ethics, that is, by sacrificing whatever obliges me to also respond, in the same way, in the same instant, to all of the others (Derrida 1995, p. 68).

However, the problem is compounded by the nature of this other. Derrida argues that the individual is always "*tout autre*", or completely different, as a function of freedom (Reynolds 2001; Derrida 1995). However, this conceptualisation presents difficulties in relation to self: relations with the other, if the other is always "*tout autre*", would be impossible. What is important in Derrida's construction is that the other can never be known *completely*. Hence the other can be viewed as both known and unknown to the observer: known inasmuch as s/he is there, and displays characteristics similar to the observer (by virtue of her/his humanity or nursing aspirations); unknown in that one can never know the other in her/his entirety on the grounds of one's separateness. Indeed, there is a notable similarity here between what Derrida is proposing and what Anderson *et al* (2001) found in their study into attributions of blame to rape victims: it will be recalled that their subjects sought to consider the victim's

characteristics and behaviour *vis-à-vis* themselves prior to coming to a decision about responsibility for the outcome.

Working with Levinas' thought, Derrida suggests that, precisely by virtue of having engaged with the other, one acquires a moral responsibility towards her/him such that decision-making, in order to be entirely just, becomes impossible. Derrida calls this condition undecidability, a term not simply indicating indecision on the part of the observer, but a reference to the dilemmas inherent in any situation in which it is necessary to obtain justice rather than simply follow some programmatic path to a conclusion (Derrida and Caputo 1997). In an example cited by Edgoose (2001) application of the universal rule – standardised assessment criteria – may lead to possible deleterious consequences for a weak but improving student. To vary from the rule implies different judgements for different people, although all ostensibly occupy the same learning space, and are subject to the same standards for judgement. So the particular decision has implications for everyone else.

Derrida (1995) holds that dealing with such dilemmas necessarily involves, first, an acknowledgement of the universal rule – a given set of outcomes, for instance – so that we know what we are concerned with; but this must immediately be suspended, in order to allow a proper consideration of the presenting problem. Second, we have to recognise the undecidability of the present situation, precisely because of its particularity, its difference from the general. This is not to be understood as a deflection of responsibility, or as indecision; as Caputo states, "the opposite of 'undecidability' is not

‘decisiveness’ but programmability, calculability, computerizability, or formalizability” (Derrida and Caputo 1997, p. 137).

Third, there is urgency: we cannot escape from the need for a decision. Practitioners are obliged professionally to make a judgement. Derrida refers to the moment of decision-making as one in which the impossibility of accommodating both the universal and the particular is seen. It is worth noting that Derrida is emphatic in pointing out that this does not mean that there is no call for the programmable, that is simple, straightforward decisions: the carrying out of specific procedures, for example, can be judged in this light. Derrida merely advises that there are limits to the calculability of more fluid situations if one is to achieve justice. The removal of judgement from such problems would lose the humanness of the objects of judgement. Absolute adherence to the universal rule would deny the possibility of alterity, future change, and possibility, and this would make it unjust. Again, my analysis will show how participants managed this problem.

RELEVANCE TO THE PRESENT STUDY

There are important links between these views which resonate with the purpose of this study. For Derrida, difference is important because it recognises the particularity of each situation; without this recognition human action is reduced to a set of computations. For Foucault it is important because it resists interestedness in the formation and legitimisation of knowledge claims, highlighting the suppression of otherness, and the strategic and political nature of claims to knowledge. Deleuze and Guattari see difference as crucial to the

creativity of humankind; universalising knowledge claims reduce human potential and seek to gain control of troublesome otherness. Difference, variability, unpredictability are the key to productive human action. The universalising, essentialising tendency is concerned with control, predictability, and the elimination of what is seen as randomness, whereas ambiguity – rather than randomness – and lack of absolutes are necessary to creative, hence productive, human responding.

Given the evidence reviewed in the last chapter, what appears to count for one practitioner (or set of practitioners) does not necessarily hold for others. This is despite the fact that all are concerned with the practice of nursing, with the assessment of others' developing practice, and are using rationally determined, comparable criteria taken from official (*ergo* ostensibly well informed) guidelines, under broadly the same conditions. Such variability challenges the idea of structures and systems which operate to direct individual action: in the present context, a common set of values, a common understanding of the goals to be achieved (safe, competent practice), and of the means of their recognition. Widespread evidence of disagreement and inconsistency in what counts as acceptable practice leads to the need for a more relativist understanding of the knowledge accessed by practitioners.

Cromby and Nightingale (1999) claim that real structures exist independently of our representation of them. Similarly, Wainwright (1997) suggests that these necessarily constrain the actor's range of options in a cause-effect relationship with social activity, the evidence for which is to be found in their consequences.

It follows that the values and obligations of nursing, made explicit through agreed documentary guidelines, and independent of any individual nurse's representation of them, should reliably direct judgements of practice development, and lead to orderly, consistent judgements of students' performances. It has been shown that this is patently not the case; such widely reported variation points to the possibility of another kind of explanation.

I want to suggest that, while we may agree readily that 'real' problems – real, that is, to those experiencing them – are encountered and responded to in clinical settings (e.g. that people have health difficulties; that psychological and social factors influence the achievement, restoration, or maintenance of health; that the presence or absence of resources affects what is done; or that procedural skills are necessary for delivery of appropriate care), the world of nursing *practice*, and judgements about it, are more fluid than can be captured by a single over-arching representation. The stealthy introduction of competencies as a measure of acceptable practice has more to do with political interests (*cf*. Foucault 2002a, 1977a; Potter 1996) than with epistemology or ontology, yet it has come to dominate representations of nursing work through a managerialist discourse which promotes an economic model of practice (Stronach *et al* 2002).

Variation in response, the failure of pre-programmed decision-making (*cf*. Derrida and Caputo 1997), implies that different points of reference, of what counts, operate according to the characteristics of particular situations. In effect knowledge and judgements of practice are better thought of as contingent. To

impose a definition of nursing practice – *ergo* the version of knowledge brought to bear on clinical situations – based on technicised descriptors smacks of subjectivism, leaving practitioners no opportunity to define their activity more authentically for themselves. In these circumstances it is the relative power and status in the social relations amongst nurses, which results in the *apparent* acceptance of the notion of competence/ies by practitioners. Deleuze and Guattari's (1988) notion of "territorialization" in the interests of another can be seen. As Usher and Edwards (1994) argue, variability is far from mere untidiness: it is fundamental to human representations of the social world. Alternative, contingent versions are inevitable and, indeed, desirable in the panoply of human experience and action. Hence, difference operates as a source of strength not weakness, since it acknowledges the contextual dependence of practice.

Accordingly, I have adopted a perspective from which localised understanding is valued, rather than subsumed by overarching frames of reference (Sarup, 1989). I will suggest that individuals move about within a field of knowledge, understanding situations on their own terms, defining and redefining themselves more freely than is allowed by universal conceptions of the self or the world at large. To paraphrase Milovanovic (1995) this allows for the productive use of localised difference, through fluid understandings, spontaneity, indeterminacy, and what he calls orderly disorder. Such a characterisation, while it also involves negative possibility, suggests that some kind of order will still be evident, but not the fixed, rigid order implied by a modernist view. Variability and flux are desirable, as is tolerance of difference,

since it is from these that creativity and change will result. Knowledge fields are constantly reworked and redefined, as Deleuze and Guattari (1994, 1988) argue. Individuals, too, are constantly reworked and reconstructed, as Foucault has proposed (Foucault 2000). Practitioners are not merely incompetent in applying assessment criteria; they are making situated judgements.

CRITICISMS OF POSTMODERNISM

The postmodern perspective is not without its problems or critics. It has been read as a position in which anything goes (e.g. Archer 2000): if difference and contingency is to be wholly accepted, then whose values, if any, are to be used to regulate social life? Without a unified understanding, a universal ethic, life is fragmented and in chaos. Bauman (1995) offers a powerful riposte to this possibility. He argues that difference paradoxically lays more responsibility on the individual to act morally, since choice is now wide open, not restricted to a single given view. This resonates with Derrida's concerns about otherness and justice in decision-making (Reynolds 2001), and with Foucault's view that lack of freedom and the absence of resistance leads to sterile domination and compliance. The latter position has something in common with the historical characterisation of nursing as an occupation (*cf*. Pask 1995; Lorentzon 1990), while the former recognises the fluid nature of the situations in which practitioners find themselves as assessors of student performance.

From within the movement Deleuze and Guattari (1988) have drawn attention to the need for individuals to make morally defensible choices, even though the knowledge planes to which they have access contain all possibilities, desirable

and undesirable, and are the targets of territorialization by others: individuals have a responsibility to choose, rather than simply comply with a predetermined view. Indeed, postmodernist writers tend to recognise the ever-present danger of the harmful choices, rather than support the suggestion that anything goes. There are instead frequent references to morality and justice (Bauman 1999, 1992; Derrida and Caputo 1997; Deleuze and Guattari 1988; Foucault 1980), but based in the situated world of the everyday not the idealised.

Much criticism is aimed at the destructive tendency of postmodernism, or at best its lack of commitment (Francis 1999; St Clair 1997), claiming that it seeks to undermine, offers frequent criticism of claims for what has been achieved, but puts little or nothing in its place. In a counter to this Johnson (1981) points out that, for instance, the technique of deconstruction is closer etymologically to analysis, in the sense of undoing something. It is not about destroying what is there, but understanding the conditions in which certain claims have arisen. The relevance of this position to the context of the present study is clear. It is already well established that prescriptive approaches to assessment do not work, so I am asking how practitioners account for their decisions in practice, not trying to reveal why they are incapable of following a predetermined order. The challenge is to the unequivocal claim for one version of truth or reality over others. Potter (1996) has demonstrated that claims to truth are influenced by more than scientific objectivity, and that they frequently operate less in the interest of cohesion than of domination. Paradoxically, it is the claim to absolute understanding which raises the greatest danger: truth is truth as long as it is defined and controlled by, and working in the interest of, the powerful.

Deleuze and Guattari (1988) show themselves to be very aware of undesirable possibilities, when they describe their un-predetermined Body without Organs (BwO): a notion that knowledge or identity is always in a state of flux, of becoming something other than what it is. There is a clear parallel between this and how participants in this study appeared to view their assessment decisions: they anticipated future development and situational demands. Deleuze and Guattari argue that choice, not constraint, is crucial, but always with regard to the consequences for others. For instance, in respect of the masochist's search for pleasure and self-expression, they make the following observation.

> That there are other ways, other procedures than masochism, *and certainly better ones*, is beside the point; it is enough that some find this procedure suitable for them. (*ibid*. p.155, my emphasis)

Their hesitation clearly recognises the implications of this statement, a point reiterated a little later, indeed on numerous occasions in their writing. In the forming of these so-called BwOs they tell us that we must

> [take] charge of desires, of assuring their continuous connections and transversal tie-ins. Otherwise, the BwO's *[sic]* of the plane will remain separated by genus, marginalized, reduced to means of bordering, while on the "other plane" the emptied or cancerous doubles will triumph. (*ibid.* p.166)

In this more fluid way of viewing the world, then, humankind is not to be seen as mere flotsam in a sea of possibilities. Instead individuals must take an active part in making the best of the possibilities presented to them through experience. Similarly, practitioners must be allowed to take ownership of their actions in context, whereas the content of assessment packages to date has been other-defined. In Deleuze and Guattari's conception of knowledge

undesirable possibilities are always present. Fields of immanence, planes of consistency are constructed under different conditions, and result in different formations, but, while there will be aberrations, “the question, rather, is whether the pieces can fit together, and at what price” (*ibid.* p.157). They are here recognising that there will be different results according to the complex of conditions under which any solution (the outcome of interaction) is built, so there can be no one fixed way of acting, knowing, or being. The play of moral responsibility in choice comes to the fore.

In another critique Giddens (1984) has challenged Foucault’s analysis of the division of space and time, as the means of gaining greater efficiency through control of the human resource. Giddens complains that, since the examples are taken from closed institutions such as prisons, hospitals, schools, military camps, then, as a model for wider society, this is inapplicable, since, on entering these places, individuals lose the right to act individually, or to engage in the activities accorded to ordinary subjects. Such organisations operate through a corporate, not individual, identity; so, since people are freer in society than in these settings, social control through disciplinary discourses fails as an explanation.

However, Giddens’ argument appears to ignore other ways in which social division can occur. For instance, any occupational group over whom some degree of control is required (especially, perhaps, professional ones, where the limits are difficult to prescribe), whether for economic or political reasons, will be subject to the kind of limitation with which Foucault is concerned. Against the

background of my own study, this understanding holds up well: practice is constrained by managerialist considerations of accountability, now well established in the language of nursing practice and training. Indeed substantial change has occurred in the way most professional occupational groups are increasingly tightly described and defined over recent decades (*cf*. Perkin 1989). While Giddens concedes that Foucault's notion of discipline can work if there is a trade off against other aspects of life, the argument fails to address the point that, by virtue of their entry into a particular professional group, individuals concede some of their own freedoms, at least while acting within that role. Thus he moves Foucault's analysis closer to his own notion of duality and interdependence in structuration.

This is then suggestive of the more mobile notion of self found in Foucault's later ideas concerning the ascetic constitution of the self (Foucault 2000), as well as implicating resistance to and transgression of discursive boundaries. However, Giddens rather evades the question of the possibility of internalisation of disciplinary ways of knowing and acting, when powerful groups invade (or, in Deleuzian terms, territorialize) training systems. For the purpose of this study a model of competent practice which privileges performativity (Lyotard 1984) over, say, compassion or discretion (Wade 1998), undermines more open, more responsive ways of thinking and acting. As Lorentzon (1990) has observed, training encourages practitioners to become proficient at self-monitoring: competencies, once having acquired widespread approval, determine what counts as acting or thinking professionally (*cf*. Fournier 1999), and add to the armoury of self-control mechanisms. The functioning of closed

or disciplinary systems differs little in principle from the panopticon; I examined participants' accounts of their work while allowing for this possibility.

Archer (2000) is more hostile to postmodernism, condemning it for its concern with destruction of the self as agent, and for placing mankind unhelpfully at the mercy of circumstances. For her, it is the mutual interaction between humans and their world that constitutes "the transcendental conditions of human development" (p.17). She sees humankind as active in this relationship, and holds that, since such relations are universal, they anchor and limit the variability of human development. Archer is concerned that, if there is no fundamental self which can be captured, then humanity is lost; indeed, she seems to imply that postmodernism has the power to transform humankind into something other than human: "Humanity, as a natural kind, defies transmutation into another and different kind" (p.17). Our interactive relationship with the world underpins our moral and political responsibility to others.

However, this would appear to constitute human selves in terms of moral responsibility to others, a view with a striking similarity to Levinas' (1969) concern with responsibility to the other; or Derrida's (1995) concern with justice to others. Indeed, Archer's argument is countered by Bauman's observation that it is by virtue of postmodernism's rejection of the universal that responsibility and morality come to the fore, since there is no predetermined guide for action (Bauman 1995). From my reading of her argument Archer (2000) overstates postmodernism's mischievousness, while playing down the serious project of challenging the universalising preference. It could, in fact, be

argued that the vigour of her commentary paradoxically provides an example of how discourse might be constructed: through the selective inclusion and exclusion of particular viewpoints and claims. While she complains that postmodernism itself is selective, her commentary fails to acknowledge the legitimacy of the challenge to more conventional thinking as a given. By contrast, both St Clair's (1997) and Francis' (2000) critiques draw attention to the lack of a definitive worldview within postmodernism, but see the need to question claims and assumptions arising from other perspectives.

Finally, power – hence power relations and the idea of resistance – is a difficult concept in Foucault's writing (Hindess 1996). If individuals are controlled through the power of discourses, then it would seem, according to Heiskala (2001), that power is no different for Foucault than in other conceptions of it: powerful *a* applies it to *b*, unless *b* has some means of acquiring a block of it, thus reducing *a*'s relative power. Hence, power remains the structural force of more rationalistic views of it, and the individual a passive target of power-driven interests. From this point of view, Foucault's account of discourse is said to be too restrictive, and so not fundamentally different from other approaches. In this light, his later writings are seen somewhat sceptically as a response to such earlier critiques, and as an attempt to reintroduce the actively self-constituting agent. However, by introducing a conception of power as a dynamic, *strategically deployed* force between different interests vying for influence, combined with the notion of the self-constituting agent, Foucault presents a more productive, less sterile, more optimistic view. Katz (2001) adds that while Foucault's case studies might be criticised for their historical oversights,

nonetheless, they “illustrate how specific problems arose in particular historical conjunctures” (p.125). The perspective I have adopted in this study increases the possibility of a greater sense of justice, since it allows for the contingent nature of practitioners’ judgements. The site of interest remains the territory inhabited by individual practitioners, their construction and use of knowledge, and the problems of decision-making and fairness.

DATA COLLECTION

Following this line of thinking, too structured an approach to enquiry would have limited the possibilities for understanding participants’ responses; the form of the question may determine the range of possible answers (*cf*. Anderson et al 2001). Conversely, too loose an approach would lose direction in the study; the enquiry is set up for a purpose, for all that this was my own. Mindful of this, I sought to avoid the intrusion of personal preconceptions into participants’ explanations, in the manner of Schutz’s stranger (Schutz 1964). This was intended to allow practitioners to give their own accounts of events, and avoid undue assumptions arising from my position as an insider-researcher; many of the eventual participants were known to me, and therefore likely to assume a shared understanding existed between us. On occasions this resulted in a rather crass formulation of questions; for example, why is safeness in a student’s practice considered important? However, while this issue was understandably always responded to as self-evident, the intention was to avoid any assumptions about how they would know this. Such questions were followed up with an invitation to explain how they construed safeness, a much more interesting question.

Spradley (1979) has described an approach to enquiry which accommodates these concerns: the ethnographic interview. He compares this to a conversation, in which the participants engage in an exploration of a topic of mutual interest. However, he also distinguishes interview and conversation through other characteristics – explicit purpose, inherent explanations (of purpose, for example), and particular forms of questions, especially from the researcher. These fall into three main categories – descriptive, structural, and contrasting – intended to bring out, respectively, terminology, knowledge organisation, and distinctions in the meanings of terms used. Initially participants were asked to describe the criteria they used, through a focus on familiar experiences: how were good and poor students identified; what kind of description was offered and how were distinctions drawn? Participants were then invited to articulate how this understanding was organised and deployed: why, whether or how criteria were varied; what counted as evidence; whether judgements were presented for public consumption, or disguised through approved terminology? Following this, questions focused on uncertain performance: whether, for example, subtler judgements were invoked, hence fine distinctions drawn, in such cases in the way criteria were understood or applied. In effect, the process was intended to encourage practitioners to convey meaning in their own language prior to invoking what Spradley (1979, p.59) calls their “translation competence” – its conversion into official terminology. An outline of the questions and prompts used can be found in Appendix A.

Denscombe (1998) suggests the possibility of triangulation in order to obtain a more robust understanding; for instance, students might provide an additional source of data on assessment processes. The intention would be to provide an intersubjective perspective, to confirm or refute the researcher's interpretations of data (Adelman 1985). However, it would also assume that the meaning offered by practitioners for their choice of criteria is also portrayed to students, untainted by the *student's* interest. Johnson (1999) rightly comments that this kind of strategy in qualitative research is inappropriate, since its purpose is to obtain verification of the underlying truth of any claims made. Thus, it shifts the approach towards positivism and undermines the meaning taken from practitioners' utterances, whereas what mattered was how they accounted for what they do. The student's view of assessment processes belongs to the student, and is coloured by her or his pre-existing biases and expectations. Any conflict between these two perspectives would form the focus of another enquiry.

Recruiting the participants

In qualitative enquiry it is accepted that sampling needs to be purposive and linked to the nature of the enquiry (Miles and Huberman 1998; Andrew 1985). Practitioners who had acted as assessors for a minimum of one year, were invited to participate; this allowed for differences to have occurred in their experiences of individual students. Given the different clinical contexts in which practitioners and students work, the sample drew on practitioners from different clinical areas, since there may be differences according to the general setting as well as specific (clinical) situations. It is reported anecdotally that different

climates operate in different clinical settings; this was taken into account, so that participants were included from different institutional and geographical areas. In the end eighteen practitioners were recruited, whose experience ranged from 3 to over 30 years in practice, from a range of settings: NHS district general hospitals, community hospitals, community nursing services, and a private nursing home. Brief pen pictures of participants are shown in Appendix B. Each volunteer was interviewed for approximately one hour, with interviews spread over a period of one year, with three contributors asked to participate in a second interview. They were invited on the basis of points they had made during our initial conversations, which were emerging as potentially important and influential factors. These included the way nursing knowledge was characterised; the conflict between the nurse's varying roles and what this implied about where final responsibility lay; and power and influence in decision-making.

The experience of obtaining participants – and the consequent time span of the interviews – warrants some comment here. The initial invitation, circulated *via* a colleague in a local hospital – a gatekeeper, as recommended by Denscombe (2000), for the purpose of validating the researcher's position and authentic intention – resulted in no responses at all. In my field notes I commented on my puzzlement at the time, since day-to-day experience indicated that everyone had something to say about the nature of practice assessment in current programmes. I was unsure whether a direct approach would have been more successful; a face to face request would potentially have led to people feeling coerced into participating, whereas I wanted people to contribute without feeling

that they were under duress. I decided to persist with written invitations, and reworded the invitation to be less self-interested, couching it more explicitly in terms of the individuals' *experience* of undertaking assessment, rather than as an investigation of the assessment of students. I was mindful of the impression being given that the purpose was to monitor how well practitioners were doing the job. In this case, primary data could be hidden from view in the same way as I have argued it may be hidden from official surveillance.

However, circulation of a second NHS Trust area failed again to produce any participants, leading to a growing concern that the study could fail even to get started. Questions began to occur; for instance, are practitioners so worried about talking; if recruits are so difficult to obtain, where does nursing research derive from? The continuing lack of volunteers could be confirming either the sense of surveillance and vulnerability amongst practitioners; possibly a lack of concern with research (interesting in itself in light of the emphasis on evidence for practice); or possibly lack of belief in their power to influence events. The lack of response so far was very striking; indeed, it eventually merged with the original intention to ask how practitioners claimed to know acceptable practice, and offered additional possibilities for analysis (e.g. on the relationship between clinical and educational colleagues), which I had not directly considered prior to this stage. In the end the possibility of utilising personal contacts, either amongst known clinicians or colleagues with clinical contacts, began to look more attractive. The negative aspect to this was that, while Denscombe's gatekeepers may provide access, this could simply result in conversations

between friends, therefore only mobilising already shared perspectives, and thus contributing nothing further to the debate.

A colleague, who offered to utilise some personal contacts, suggested that the difficulty could be lack of time to engage in interviews, so that they would have no option but to take time at the end of a normal shift. Organisational pressures meant that they were unable to take time out within working hours. Many clinicians also work part-time, and have family commitments; accordingly their hours of work are chosen deliberately. This explanation seemed validated when, following an approach to community teams, using the written invitation, there was a relative flurry of volunteers! Community practitioners have the comparative luxury of being able to organise their own working schedule to some extent, and to arrange colleague cover for their absence. Additionally, as one participant actually suggested, there is a high proportion of community practitioners who have studied to honours degree level in Wales, raising the possibility that their appreciation of the nature and possibilities of research may be enhanced.

Subsequent contacts were made more directly or through work colleagues' contacts; but this always had the possibility of being a response to a known individual. It would be more difficult to turn down a known face, a situation which bears some comparison with the Levinasian responsibility to the other arising from the face-to-face encounter (Levinas 1969). Given the construction of the encounter, it moved closer to covert coercion, in which power relations – between (perceived) educational authority and practitioner inferiority (Payne

1997) – might play a part. Nonetheless, the majority of eventual participants, while apprehensive about their ability to talk about their ideas and practices, appeared to be doing so voluntarily; two in particular appeared to be working with the possibility that they were under inspection, and these will be highlighted in the analysis.

Conditions for interviewing

To facilitate participants' comfort with the researcher (Fontana and Frey 1994; Adelman 1985), and to reduce possible contamination further the choice of location for interviewing was left to the participant. Following the spirit of Spradley's (1979) "ethnographic explanations" (p. 59), the purpose of the research was made explicit at the outset. The use of an audio-tape for recording the conversation was also agreed at this stage, with assurances that data were not attributable, nor available in their raw form. Consistent with Shipman's (1985) recommendation, that participants have the right to choose what they will ultimately make public, they were also assured that they had the right to withdraw at any time if they wished. It was critical that an assurance of absolute anonymity be given; nurses tend to be looking over their shoulder to protect themselves against threats of retribution (Pask 1995).

Notwithstanding such assurances there was a tendency on the part of some participants to suspect my declared intentions, at least initially: several asked spontaneously if what they were saying was what I wanted. Resisting this had to be an active process throughout the interviews; and, of course, the problem is exacerbated, as Spradley (1979) acknowledges, by the need to revisit given

responses to clarify meanings, or to understand variations according to context – easily interpreted as checking up rather than clarification. This awareness had to continue into the analysis; it was always possible that I would be seduced by some neat but misleading definition lurking in the data.

The chosen technique for data gathering helped me stay with practitioners' accounts of their practices. Even so, I was aware that the enquiry would always be influenced by my own interest as researcher, since choices about what issues to pursue from amongst those offered were my own (*cf*. Schatzman and Strauss 1973). In moving away from the idea that there might be something there to be captured and bottled, as it were, I was able to see my work as an analysis of situated accounts. I was not, as I might formerly have assumed – given that I saw myself as unthreatening, and my interest as genuine and unbiased – revealing some so far undiscovered phenomenological truth.

SUMMARY

This study, then, aims to explore practitioners' accounts of their judgements, and of how they interact with official representations of competent practice. It is assumed that this is contingent, fluid knowledge. Bauman's (1999) model of the process of policy formation, particularly its emphasis on the importance of the *agora*, has value in the context of nursing. It highlights the importance of a mediating opportunity for discussion, and thus the impact of its absence on any debate about what matters amongst all concerned with the education of nurses. Indeed, on first discovering Bauman's idea, it presented an ideal match for my own perception of nursing's *modus operandi.* Practitioners and others seem

constantly to be at odds, lauding competing and apparently incompatible models of practice. Consequently their actions in assessment may show only superficial agreement, while substantive, potentially important differences persist unacknowledged, leaving students to experience ambivalence, possibly cynicism, towards their learning. Similarly, it has led to the public exhibition of inconsistency and apparent disarray in the knowledge base.

I wanted to explore the wider possibilities for assessment, without the constraints imposed by the modernist tendency *vis-à-vis* nursing practice and knowledge evident in current policy. This meant offering practitioners space and opportunity to present their own accounts of their practices in assessment of others. Chapter four commences the analysis with an exploration of the data using attribution and correspondence, but, as will become evident, this takes a more discursive turn as it develops. Subsequent chapters take an explicitly postmodern perspective to examine the complexity of practitioners' stories in a way which, for me, made better sense of their understanding of their situation both as clinicians and as assessors of practice.

Chapter 4: Jigsaws and Acceptability

I started this project having in mind the possibility of identifying how practitioners view developing competence in student performance; however, this was rejected in chapter two as inappropriate. This chapter explores the way practitioners explained their decisions on student performance, showing how their practices were initially understood by reference to attribution theory, in particular by drawing on the notion of correspondence (Jones and Davies 1965). While this appeared to be a relatively straightforward process, it became clear subsequently that there was more to this than first examination revealed. Hence, the analysis presented in this chapter proceeded *as though* decisions about student performance were made without reference to any influence from a personal or contextual agenda on the part of the participant. On the face of it, dispositional characteristics underlay all other requirements, such as knowledge or procedural skills, explained by reference to students' future status, when they would be responsible for their own development. Acceptability in students' practice was said to be made up of different elements in combination, for example, willingness to engage with learning opportunities; self- and situational awareness; safeness – all articulated as dispositional rather than technical qualities.

However, although they identified the pieces of the acceptability jigsaw with apparent clarity, whenever the pieces did not easily fit together, participants arranged and rearranged these to form something of which they approved,

occasionally finding that the puzzle was not readily resolved into a predetermined picture. Subsequently, following Potter and others (Potter 1997; Potter and Wetherell 1987), I came to see that practitioners' statements were doing a certain kind of work for them. This also took support from work by Anderson *et al* (2001), whose study of attributions of blame to rape victims shows how participants operated as active agents rather than detached observers. This perspective helped provide a bridge to the analysis presented in chapters five, six and seven.

ASCRIBING ACCEPTABILITY

At the outset of the analysis participants appeared to be seeking dispositions rather than explicit knowledge or skills as the basis of their judgements. Attributions of appropriate disposition were derived from the individual's range of behaviours, from which suitable disposition was inferred (*cf*. Jones and Davies 1965). Acquisition of, and increases in, knowledge and skills were taken as evidence of appropriate actions, arising from and demonstrating acceptable disposition. Participants identified numerous examples of behaviours to indicate that a student was meeting expectations, apparently starting from the idea that, since they want to be nurses, they would do that, wouldn't they? Where the desired characteristic was judged to be present in a given individual, practitioners were generally content with their own judgement. Where it was absent, then allowance was made for individual circumstances. Whenever an observed behaviour did not fit with expectation, or whenever some increase in knowledge or skill was deemed not to have occurred as expected, alternative explanations were actively sought prior to the ascription of unacceptability. The

process conformed to an assumption that inappropriate action may be attributable *either* to circumstances (including the student's experience to date) *or* to the individual, when answering the question: what is the *intent* of such action?

This view fits well with Jones and Davies' theory of correspondence, in which expected actions tell us little about individuals, other than that their actions are congruent with their goals. However, despite their claim to have a clear idea of what made a student's practice acceptable, participants would go out of their way to find, or even suggest, alternative explanations, since the expectation of engagement was held very strongly. Consideration was given to a wide range of other possibilities such as shyness, lack of opportunity or guidance, or to the mere strangeness of a situation; participants would even speculate about a student's personal circumstances before ascribing non-acceptability. While the initial process of attribution seemed to fit with an almost algorithmic procedure leading to predetermined answers, the extent of their desire to make allowances pointed to an alternative explanation, and this will be considered in subsequent chapters.

Disposition *vs* technical achievement

With very few exceptions participants did not use managerialist terms such as standard or competence, which would imply some fixed target. They looked for evidence of appropriate disposition for (learning about) nursing, in the form of engagement with opportunity, necessarily leading to increased knowledge and/or skills according to opportunity. The attribution of a particular disposition,

derived from observed actions, was said to lie behind the judgements made. Most participants made this explicit, and those who initially focused on acquisition of technical knowledge and skills rather than disposition *per se* shifted their positions as they explored the thinking behind their judgements. The disposition sought, commonly linked to a notion of a caring individual, was presented as crucial to the judgement that someone was a *good* (potential) nurse, and distinguished these students from those considered merely adequate. Where it was used at all, the term competent commonly indicated only a minimally acceptable level of performance. For instance, in response to a question about what she meant by it, Nan said,

> Nan: Yeh, it's just something that they have to … they have to reach, to perform to – you know, they could be a robot doing the job…[It's] a mechanistic approach…

Participants consistently emphasised the humanistic nature of nursing – even those who had the greater concern to ensure technically correct practice – and this contrasted markedly with the growing emphasis on competencies as the absolute means of measuring practice and training outcomes. Several participants expressly cited anticipation of future good practice – construed as actively pursuing continued development – as part of the rationale for looking for this quality in the first place.

It was noticeable that the most immediate attribute identified by the majority of participants was a positive and active disposition to learning. This was characterised as interest, enthusiasm, keenness to learn, wanting to be there, personal engagement with the situation and with available learning

opportunities. No definitive list of knowledge or procedural skill was said to be expected; indeed all participants declared this to be impossible, and so it was deemed an inappropriate criterion for judging acceptability. This kind of claim already anticipated Deleuze and Guattari's (1994) knowledge planes, in which knowledge reappears across time and space according to need. Participants claimed no other significance for particular elements than as examples of skill which a student might be expected to demonstrate in particular situations following exposure to particular opportunities. It was much more common for participants to look for evidence of incremental change in knowledge or skill, rather than a definitive bank of either.

Overall, three general aspects of disposition were spoken of: engagement, self- or situational awareness, and safeness. Engagement was explained as the visible action consequence of appropriate disposition; self-awareness and safeness were described as functions of disposition, rather than of particular knowledge or skill levels. Self- and situation awareness only carried weight if accompanied by the tendency to act appropriately. Safeness in practice was based on a judgement of the individual's willingness and inclination to seek guidance, or to check understanding or skill, prior to acting, particularly in new situations. These concerns were described as illustrated in the extracts below. The picture that develops anticipates the Deleuzian notion (Deleuze and Guattari 1994, 1988) of fields and rhizomes, in which elements of knowledge are interconnected, rather than found in discrete, unified, and linear patterns: participants were clearly picking up ideas, concepts, considerations, and using them for their own purposes.

One participant in particular summarised the attributes apparently sought by all in the first few lines of her response, and these were consistent with those identified in others' accounts of their activity. This was possibly the most comprehensive and succinct statement of the criteria apparently sought to be presented in any of the interviews, and so is reproduced here at length.

Toni: Right, if I'm looking for a good student, I would look first at their attitude towards their own self-development. Erm, I would look at their attitude, whether they were eager, whether they would, had looked at what the placement was about; whether they understood what was expected from them. I would look for somebody who identifies their weaknesses, and is confident in themselves to ask you to help them develop as a nurse. So, they, that, if somebody says to me, "I don't know how to do that," I would be more happy with that student, because I know they're not going to put the patient in danger. They're aware of their limitations.

Toni, a hospital based nurse, was evidently orientated to student characteristics, rather than to technically discrete criteria; in her comments she has raised, in quick succession, the issues of engagement, self-awareness, and safeness, the latter two points arising from an appropriate disposition to learning. Stella, a community-based nurse, initially, and unusually amongst the group, set out by describing at length how she demonstrated to students what she expected of them, but again pointed to her expectation that a student should show observable signs of active engagement with learning – following which the good student would move towards the kind of performance she had outlined in her extensive opening comments about standards. She concluded,

Stella: It would be somebody that, at, at the end of everything that I'd, I performed with them, that, that, when we're reflecting, that they'd picked up on key things; or they said, "Well, I", perhaps, "don't agree

with that"; or…

Another community-based view was expressed by Rena, who indicated that students were to some extent pre-judged according to their response when invited to visit the placement base prior to commencement, although she claimed that she remained beyond this. Students always had the option not to take up this offer, but

Rena: I have had students who say, "Oh, no, well I know where it is; I prefer to come on the day." It's their choice. Erm, and I think, well, that shows that they're not particularly motivated!

For Rena this was apparently problematic in a student, and it is difficult to see that she would not be affected by a student's initial responses. She went on to illustrate how she would know whether a student had this quality. Having made reference to a couple of students who had not thought far enough ahead to work out how they would arrive at their placement base (and therefore had to telephone for directions on the day) she commented

Rena: It was very hard going with those two students, to be honest. It was very hard going. But I think that … the motivation, I think is … and the interest is the first thing that I assess on somebody.

This criterion seemed to play a prominent part in this practitioner's thinking. Given that these students had not even appeared yet, early evidence of interest was proposed as an important personal characteristic. Interest, enthusiasm, motivation – dispositional attributes – were claimed by all participants to be possessed by those who would, as another participant, Nina, put it, "go the extra mile" both for patients' well-being, and for their own learning and

development. This was about willingness to find something out for a patient, or to stay behind at the end of a shift, or to put oneself out in order to access some new learning opportunity. The point was caught in another (hospital based) participant's comment.

Mavis: Erm, and then you go on to eagerness to learn. Are they interested in what they're…? Are they there because they have to be there? Are they there because they want to be there? And what do they want to get from the placement?

Her point was focused on active engagement with what was available, including, for both these practitioners, some pro-active planning to inform their learning during the placement period. While a student would not necessarily be failed for lacking this quality, it distinguished the good from the satisfactory, or, as they would all acknowledge in the course of their commentaries, the merely competent. In another conversation, Nina, a hospital based practitioner, pointed this out, when describing a merely adequate student she had mentored.

Nina: There was no impetus, and she certainly wasn't motivated to go and see extra things. There was nothing from her to say, "Can I go and do?" So you would say to her…erm… "You're working in this team, these are what your tasks are". She could do that. And she would do it. But… there's nothing extra, over and above that.

This particular student was deemed no more than adequate, then, on account of her doing what was necessary, but no more. She seemed to require prompting all the time, in order to encourage her to develop or extend her understanding. There was a clear expectation that the student should be taking the initiative to remedy, for example, some identified knowledge deficit.

Nina: I always said to her, “Well, if you can’t remember the name of a drug, don’t worry about it - but what should you do?” So, I mean, she could tell me –“Go and look it up in the BNF”…

In this student’s case she was not actually doing this, hence she was judged as failing. In the course of this exchange Nina illustrated another, linked facet of the good student (and ultimately the acceptable one: greater allowance was made for early stage learners, who were judged less harshly following identification of any omissions or deficits). Her concern was twofold. The student should be taking active steps to rectify her deficit; but she would also need, in the end, to show a clear improvement in her knowledge base.

Nina: …you know, you’ve got six zillion things to do – would you be looking it up in a BNF on…over every drug? I said, you’ve got … there’s got to be some kind of concentration on the important ones…

The requirement here seemed clear: there should be an incremental change in the student’s ability to recall certain items from memory. Nina explicitly recognised, in her reference to “the important ones”, that students were not expected to remember everything they ever came across, a condition frequently cited to acknowledge the impossibility for themselves of ever holding all relevant information. While the student’s goal was the achievement of specific knowledge according to context, the underlying focus was on her tendency to put in the effort to increase what was known prior to the encounter with new opportunity.

What of knowledge and skills?

A number of participants set off with (for them) the perfectly obvious point that students needed to know what they were doing, which seemed to imply some pre-set bank of theoretical knowledge. For instance, Mavis commented

Mavis: Oh, yeh! They've got to know why they're doing it, otherwise not bother … isn't it?

K … it's not sufficient, then… [W …just to do …] that they just get good at the skill?

Mavis: No – they've got to know why they're doing it.

So here she was looking for evidence that the student could articulate her reasons for certain actions. However, it quickly became apparent that, in this instance at least, this was because it may affect a patient's confidence and well-being, as she explained when encouraged to expand on this.

Mavis: Well, you can't just do things to patients without knowing why you're doing them! And the patient wants to know what they're doing, won't they? And why they're doing it … They need knowledge, don't they? Teach the patients, what you're doing, and why you're doing? … The patient says, "Why you doing that?", and they don't know, they've lost the confidence in that student then, haven't they? … So that patients… a lot of patients can feel, "If that student doesn't know what she's doing, why is she coming to me?"

What appeared at first to be an emphasis on knowing something in its own right had now moved to a position where the claim about a certain level of knowledge was part of the relationship-building process with patients, because it facilitated confident interaction. On this account development of one's

knowledge base is necessary as much to facilitate interaction and confidence as to understand procedures, and it remained context-bound, not absolute. This shifted the focus back to disposition rather than technical achievement: what was required was the means to interact more effectively, in the interest of good care. Once again, dispositional quality was given prominence, with the emphasis on purposeful engagement. Particular items of knowledge were evidence of engagement with people, as was confirmed in the next comment.

Mavis: Well, yes, you…you've got to have an understanding of why you're doing it, haven't you? But whilst you're doing it, it, sort of, connects together, if you like…

The emphasis was now on involvement, and consolidation and development, through practice, a point matched by May, who expected that students would have acquired certain abilities, but still needed to refine them.

May: …so by the time they come to me, all they should be doing is practising them a bit more, you know. … So … they get competent with them.

Another hospital based participant was concerned with a baseline level of interest, and professional awareness, combined with a tendency to engage with people. In building up her picture of the desirable student, Marje explained that she expected some basic qualities.

Marje: I would expect basic communication skills – eye contact …like I say, not hands in your pockets, and looking at the floor, or in the opposite direction. I expect them to be attentive to the patient…professional, I think. And…it's our duty to …approach a patient in a certain manner, and give the patient a certain amount of control. … and not leaving the patient to feel vulnerable or uncomfortable.

In these comments Marje was concerned with non-technical aspects of nursing work. She had already suggested that technical skill *per se* was inferior to disposition in an earlier comment.

Marje: So somebody who's a good nurse can learn how to give a bed bath – and you can teach a monkey how to do a lot of the skills that we do, or procedures that we perform. And there are things I've learnt from scratch – I wasn't born with those skills. I think you can acquire communication skills as well, but I would expect them to be… to smile and be friendly, polite and that.

Disposition appeared to take priority, in that it must be present first; knowledge and skills come later. Comments also demonstrated how, even when there appeared to be nothing wrong with what a student did know, or with the skills s/he possessed at the time, there was an expectation that in the course of learning to nurse, it was important to demonstrate a willingness to extend or consolidate knowledge and skills through their application and through engagement with others. In the following extracts participants suggested that knowledge and skills were developed or consolidated through repeated practice, not merely acquired at the first encounter; this was still an active engagement with opportunity.

Mavis: …the good student, if you like, will come and she will do repetitive work every day, 'cause that's part of nursing. Sometimes you do get, you know, repetitive things with different patients… But they'll do it and they'll learn from each time they're doing it.

Another participant described a similar means of judging success.

Nerys: The two go hand in hand - you need the knowledge to be able to … provide the nursing care, because you need the knowledge to know what nursing care you're going to deliver. But … I find sometimes you

> get a student that will have an awful lot of knowledge, but…they don't always show that they want to be with the patient.

In Nerys's comment it was important that the student show his or her willingness to engage, rather than merely that s/he had acquired particular knowledge. It was not possession of knowledge, or its mechanistic application, but willingness to apply knowledge while engaging with people that seemed to matter. That knowledge is developed through contact with patients was then made explicit.

Nerys: … I would be happier with the person who wants to be involved with the patient, and continue to learn with the patient as well.

> … I think the knowledge is important, but you can gain the knowledge as you're going along as well. But you're here…we're all here ultimately for our patients, and … You can't go into a nurse's role, you can't go into a ward with no knowledge

In these passages Nerys seemed to emphasise that it was more important to make and develop the interaction with the patient, and to apply what one knows, to develop it further, than simply to know something. For her, active application of knowledge was crucial, but this seemed to show that a student's approach was appropriate. Taken alone the final sentence in the second extract would appear to laud knowledge above other elements of practice, but it is important to see this as a part of a continuous explanation started in her earlier statements.

May made a similar point about the connection between active involvement and knowledge or skill development. In answer to a question about whether motivation was enough on its own, she stated, with a little incredulity,

May: …if they were motivated then… why can't they do anything?! *[Laughs]*

Her point here was that motivation leads to engagement with opportunity, and thus inevitably knowledge and skill development. For her it was not credible that someone should have been appropriately motivated, hence engaged with learning, and not have gained something. This would only be possible if s/he had had no opportunity to develop particular skill or knowledge through contact with patients.

An extension of the notion of disposition (or even characterised by it) was the need for active communication, not as a technical skill, but as willing and pro-active interaction with others, both patients and colleagues. The point was made emphatically, again by Nerys, when she commented,

Nerys: … I know when I was a student, if I didn't understand a condition, [it] didn't matter to me - at the time - because the…the patient and what they were displaying mattered, and I'd find out what the rest of it meant later.

Her emphasis here was on the need for active involvement to develop understanding of the functional consequences for individual patients of different conditions and disorders. Concern seemed to be with the need to recognise the patient's present state, rather than with knowing the detailed theoretical background to the condition, which would enhance decision making later if

necessary. This was an interesting point in that it placed knowledge of underlying physiology elsewhere – with doctors, perhaps – whereas the nurse's role was with the patient and his or her current experience. This explained more adequately the need for appropriate disposition to people, and to learning from and through them.

Further evidence of this orientation was provided by Mavis, who came from a different clinical environment from others cited above. She highlighted eagerness as a key indicator of acceptability. Of the good student she said,

Mavis: Well, er, she's asking questions, appropriate questions about patients, she's eager to learn, she's sort of, at the side of you, "What you doing, why you doing it?" She's learning from her experience, she's talking to the patients, as opposed to got her head in a book, if you like, in the office, which some do…

For Mavis the willingness to become involved in care delivery was apparently preferred to developing knowledge in an abstracted way, away from the opportunity for its application. Involvement with patients, and with *doing* nursing, was core; her perspective seemed complete when she finished the above statement.

Mavis: …why are they there, do they want to be nurses, or do they want to be teachers?

It was active engagement with, rather than detached (theoretical), learning which was said to matter, and this was further dependent on willingness to apply and extend it. This comment also pointed to another aspect of what seemed to characterise good practice in students.

Situational awareness

On the face of it, the last statement implied that book learning was for some other purpose than practical nursing. *Vis-à-vis* correspondence theory's link between behaviour and presumed intent, book learning may be important and appropriate for the student. However, for this practitioner it must be combined with awareness that there is a time and place for consulting text-books. According to circumstance, there must be some recognition of team membership and responsibility – both associated, for Mavis, with professionalism – demonstrated by actions signalling membership of and responsibility to the team. In this respect a concern with book learning at inappropriate times supported the requirement to show engagement. Students were expected to show awareness of the demands on other team members at particular times, and willingness to contribute to the work. There is an uneasy tension in this, since students are technically supernumerary; but students must learn to read the situation accurately, and then respond to match this. Mavis made this point a little later; when asked if it mattered that a student had isolated herself in the office to read a book, she responded,

Mavis: Well, it does if it's Bella or Best or something! … it depends on the workload. I mean, you know what the wards are like, you're so short staffed, and if you see somebody sitting down, we do think why are they sitting down whilst we're running round like fools … But if they're there, to learn on the *[type of ward]*, and they've got the time for studying books at home, haven't they? …

There were two issues here for Mavis, also raised by others. She started this comment by making reference to recreational reading and distinguished between this and work-related reading, apparently recalling some actual

observation indicative of inappropriate judgement on the part of the student. The point was ostensibly an obvious one; but it pointed to a disposition to act in support of colleagues. Her second point was that there had to be an awareness of the demands of the particular situation, matched by concordant, supporting actions.

May drew out the nature of this requirement at some length, to capture the need to read situations, act appropriately within them, and not allow oneself to be distracted. In thinking about this, she had made a reference to common sense earlier in our conversation, and had now come to some understanding of what she meant by this. This description came after she had acknowledged that a particular student was very able academically, but appeared to "lack common sense" (her words). As she developed this explanation, it became clear that common sense had to do with situational awareness, and involved prioritising activities according to the demands of the situation. Her first comment, in what was a lengthy continuous passage, set up the situation as demanding on her own role when working with a student.

May: So you've got to weigh up everything, you've got to do the auxiliary's job, you've got to do your own job, and make sure the student's picking up on things. So you take people off…to the bathroom, and whatever. And we were really busy, and, erm, she'd go off and answer the phone … which I didn't think was very important!

This had two consequences – one for each of them.

May: So she'd leave me with all the work, and she was cutting herself off then.

She then explained the problem in this student's actions. The student in this instance was seen as failing to see the whole situation, which led to a judgement that she may simply have been unwilling to contribute help, which would have the consequence of lack of learning development; or she was failing to appreciate and develop a sense of responsibility for her own allocated work. Her distractibility was problematic, and implied that at best she was only responding to things she might be more interested in, or more negatively, in order to avoid having to deal with more demanding, less attractive work. She continued,

May: Or maybe she was just being a bit lazy, and didn't want to help me. Or the bell'd be ringing for the toilet, and … Whoever took that person, you'd listen out for the… bell, and … if it was your toilet going, you'd go … to get the patient back. It would save taking anybody else from…their other bays... you'd remember that you took that patient in there, so that if they were being a bit long you'd go and check on them – it was your responsibility…

Clearly, as for Mavis, the student ought to have shown awareness of, and taken some responsibility for, her part in whatever was going on at the time. Failure to do this meant that others would be overloaded, or that things would be missed. This and other considerations also contributed to judgements about whether a student was safe.

Safeness

A number of participants stated at the outset of their commentaries that students had to demonstrate that they were safe. Necessarily, therefore, they must claim to know what safeness is. Grace supplied a comprehensive yet succinct answer to the general question of how she knew a good, hence safe,

student: the initial section of this passage is abbreviated from the original, to locate safeness in its wider context.

> Grace: Right, she was very approachable … without being cheeky [*smiles*]? She took initiative, again, within her own … boundary, you know; and I think that's very important […] She took initiative in getting a conversation going […] She was a safe practitioner – obviously, which is paramount – and she proved that to me; and … was quick to say when she wasn't happy about doing a procedure, or when she wanted to learn a procedure more competently...

The statement that the student "was quick to say when she wasn't happy about" something made clear that she was not simply talking about correct procedural skills. This was very much about self-awareness combined with willingness to ask for help, guidance, clarification. This understanding was confirmed later in the conversation, when I asked what was meant by safe.

> Grace: …acknowledge their limitations…and… they're keen to … work on them, to…develop their skills, really, you know, put theory in that practice…

Here she focused directly on the disposition to check first, and followed it by the reference to being keen to develop theory and skills; later again she talked about getting it right, and returned to checking actively, on the part of the student, as the measure of safety. It was clear, as the conversation developed, that she was not talking about a student getting things right as the first measure of safeness, though this would matter once someone had taken on a particular task. She was concerned that the student would check her understanding first, by talking it through, or asking to be observed: this, she said, is what made her safe. She then implied that overconfidence reduced the likelihood of prior checking, suggestive of potential unsafeness.

Grace: … I don't like overconfidence in students. And that's not…because it puts me… makes me feel threatened in any way…

This quality was illustrated at greater length by Megan, when she explained how she would recognise safeness in a student, combining this with cautious risk-taking.

Megan: … they will come to you, because it does happen, they will come to you, "I feel confident about doing this. Do you mind if I do it, and will you check it?" And that's a plus for them, because it's building their confidence as well to do things. I mean, obviously it all depends how far they are in their [training]… But some are more confident than others to start with in any case. Without being overly confident, 'cause that's a danger of falling that way again!

While Megan finished this statement with a short laugh – I understood this to be because of the apparent contradictions in what she was saying – she was, like Grace, pointing to the active role taken by the student in checking things out before trying them. Again, being safe was being construed as dispositional, inferred from appropriate actions: checking first, acting later. May, in slightly different words, illustrated the same point, providing a further rationale behind this kind of judgement that failure to check first could lead to negative outcomes for the individual as well as the patient.

May: … If they were stuck…if they came across problems, and they were asking for help, then yes, I'd say, yes, they were safe to go on and qualify. Because when you qualify, you… I keep saying to my students, you need…don't be afraid to ask, you need to ask. You go away doing your own, you're gonna end up with no registration.

I will say more in the next chapter about the concept of safeness as constructed by these practitioners. For the present purpose it is sufficient to acknowledge that for them, as for the professional bodies, safeness was a key concern. For

these practitioners it was identified through the confirmatory behaviour displayed by the student, not through technique *per se*.

Making allowances

In keeping with Jones and Davies' (1965) theory of attribution and correspondence considerable allowance is made in any judgement cast, either to defer the final decision, or to excuse and accept the individual student's failing in individual elements of overall performance. The kinds of allowances illustrated below were widely shared amongst participants. Distinctions were drawn between late and early stage students; shyness did not debar someone from being judged satisfactory; absence of particularly common skills – those that might, in the view of the individual practitioner, reasonably be expected of anyone who has been in training for more than a few weeks, for instance – may be attributed to poor guidance in the past, or simple lack of opportunity (such as particular types of ward). In the next extract, Nina illustrated how she differentiated between early and late stage students: the former must show interest in learning and engaging with opportunity when it is pointed out to them; the latter should show willingness to take things on by their own initiative, instead of waiting for permission. The difference was fairly subtle, but was there nonetheless.

Nina: Right – what you do see is that in the early stages they will say, "Can I come and see? Can I come and do? I want to see this; I want to see that". You tend to find, as they get more experience, they're into their final year, final six months…i…it kind of turns round, and I say, "What do you want from me?… But I also expect to see motivation – I want to see this, I want you to tell me […] You…in a good student, that's what you're gonna see. "Can I – oh, I've noticed such and such is going on – I'm going to stay behind and watch it…

In a community setting Grace drew out a distinction between displays of disposition in different contexts: lack of initiative in interaction, especially early in training, did not mean unacceptability in practice.

Grace: Oh, yes, because a lot of them are very shy – particularly when they come out into the community.

Lack of interaction was not a reason for failure provided it was attributable to shyness. Following this there was an extensive description of why it was difficult for some students to be at their ease in unfamiliar surroundings; Grace was very aware of the impact of unfamiliar conditions. In a similar manner, Molly commented that students needed time to acclimatise to new colleagues; but this was alongside an expectation that they would join in, and be present at team gatherings.

Molly: …we include the students very much in that sort of social side of work. And although you may get a student who's very shy and everything, erm, may not want to go with some of the other more, sort of, the louder people if you like, yeh, you do make some allowances for that. But I think once they've been here a couple of weeks they need to make sure that, themselves, they're part of that team.

She justified this potentially heavy expectation by reference to the changing context of nursing and training. Her point here seemed to take something from the greater emphasis on individual responsibility prevalent both in wider society and in the expectations of current nursing programmes.

Molly: I think if they're in a… in nursing these days they've got to be able to take advantage of every opportunity. I think you've got to grab the opportunity. I don't think you can sit back and, and not take on these responsibilities of opportunities. I do see it very much as a responsibility of the nurse.

This was distinguished from leaving them entirely to their own devices. The expectation was akin to Nina's earlier reference to taking the initiative in learning.

Molly: I think they're very much, all responsible for their own development, for their own training; er, I don't believe in spoon-feeding. Although I will give them the opportunity to do something, it's very much up to them to take that on board.

Deference to circumstances was strong, and came through frequently, even where the reason (e.g. past clinical experiences) was not immediately verifiable. The preference for all participants seemed to be to avoid negative judgement of a student. Stella seemed to confirm this when responding to a question about whether she regarded a third year student, who was failing to show full integration into the team, as acceptable or unacceptable. The following extract has other implications, which will be explored in the next chapter, but here it served to illustrate the active movement between personal responsibility for actions and influential circumstances.

Stella: I think it would be non-acceptable, really. In that …*[sigh]* … depending on what they could, I mean if they, if they just weren't communicating well within a team, and they weren't playing as part of a team – it would depend on the circumstances, really.

The tendency to favour situational factors as the explanation, and the reluctance actually to fail someone, was nicely illustrated with her concluding statement on this situation.

… because there must be an underlying reason why somebody…

The preference to speculate about personal circumstances, rather than fail or condemn someone, was also shown by Megan, reviewing her judgement of a failing student:

Megan: …he came over to me as a very sad, lonely lad in the long term. I wondered if there's things that had influenced [him]…

CONCLUSION

From the point of view of attribution theory, then, the analysis pointed to an approach to assessment based predominantly on dispositional characteristics found in students. Changes in knowledge and skill, or willingness to confirm understanding prior to acting, provided evidence of appropriate engagement with learning, or of safeness in practice (*cf*. Jones and Davies 1965). Participants were not obviously inclined to talk about or attribute competence, understood in its reductive sense, as the leading criterion for acceptability. When the concept was raised it was characteristically deployed as a reference to minimally acceptable, mainly technical, ability, and was distinguished from a student's overall approach to the work, a much more critical factor. The various criteria accessed for judgements of student performance were organised in a loose hierarchical relationship: from the evidence adduced so far disposition appeared to be considered crucial, while technical gains were used as overt indicators of the presence of the more important criteria. Before applying a negative judgement, consideration was given to situational characteristics with a view to exonerating the student from responsibility for lack of engagement.

However, for all that the data had led me to this largely rationalistic analysis, I recognised, in reading and re-reading the data, that participants were implicitly presenting themselves as models of acceptable practice. As I continued to engage with their stories it became apparent that these were not merely detached, uninterested observations or claims, but that they were doing certain work for their owners (Potter 1997), especially in relation to safeness and their attempts to explain and accommodate students' deficits. For instance, Grace and Megan were suggesting that they avoided over-confidence and so remained safe practitioners by acknowledging what they did not know. Likewise, May was aware of what was going on around her, and of her obligation to her self, her patients, and others; Nina would when necessary put in the extra effort for her own benefit and that of her patients. By implication, Nerys was interested in the impact of clinical conditions on her patients; Mavis was motivated to get involved when it was busy; Stella and Molly were suggesting that they were good team members.

The analysis to be undertaken in the following chapters will draw out this more interested perspective on participants' practices in assessment. The implications of official requirements for their own status, and the defensive function of what they presented as their preferred notion of acceptability, will be explored. The next three chapters are concerned with the problems of knowledge and its construction, the nursing self, and decision-making, respectively. They will include a further consideration of the importance or otherwise of absolute achievement of pre-determined knowledge and skills; of the notion of safeness in practice and how this was constructed by these

practitioners; of their construction of multiple nursing identities; and of the hesitant nature of their assessment practices. Foucault (2002a, 1977b) provides useful insights into the way we understand knowledge production and the construction of the self. Deleuze and Guattari (1988) have proposed that we, and knowledge, are always in a state of becoming-other. Insights taken from the work of Derrida (Edgoose 2001; Derrida and Caputo 1997; Derrida 1995) will help understand the process and problem of decision-making faced by practitioners.

Chapter 5: The Jugglers' Discourse

"You know, we're very contradictory, nurses, aren't we?" (Megan)

The last chapter was concerned with the apparently rational process of ascribing acceptability to students' practice according to criteria determined by practitioners themselves. In contrast to the technical orientation of current policy, the predominant perspective taken was a dispositional one, hence more characteristic of what Stronach and colleagues (2002) refer to as the ecology of practice. This is problematic from a policy point of view, since it undermines the technicised model orientated to a so-called economy of practice (*ibid.*), favoured for its accountability and greater capacity for measurement. However, as suggested by Anderson *et al* (2001) and Potter (1997), the process of attribution has omitted a consideration of observer interest in judgements made about others. They have argued that observers are active, not passive, in the process, especially in relation to the implications of the judgements they make for themselves.

This chapter takes a more discourse analytic perspective on the claims of practitioners, and is strengthened by evidence adduced from a second set of interviews with a small number of participants. In Foucauldian terms practitioners developed their own discourse of practice through the construction of statements and enunciations dispersed throughout their stories, creating discursive regularities (Andersen 2003; Foucault 2002a). Through their elaborations of why disposition was said to be important they produced the

warrant for their statements about what mattered. Practitioners have to juggle numerous potentially incommensurable factors, and in these interviews demonstrated a resistance to the over-arching technical-rational model of nursing activity, though they acknowledged its place in practice. Whenever they might move beyond the boundaries of what is discursively permitted, they seemed to experience uncertainty and so moved back. In effect they were moving to and fro at the boundary, recognising that their moves were into unauthorised territory.

THE PRACTITIONERS' DISCOURSE

Practitioners developed a multi-faceted discourse concerned with the continuous process of learning about and doing nursing, first accessing one, then another, aspect of knowledge, then moving back to the first, or to yet another. Deleuze and Guattari (1988) argue for a rhizomatic conception of knowledge and the self which is non-linear yet always connected. They want us to understand that knowledge is not dependent on the linear refinement of its truth, but that ideas can be picked up and refashioned, yet still belong to the same field of understanding. Thus, the limit imposed by a unifying approach to nursing knowledge – its rationalistic refinement and inscription in predetermined activities or attributes – and its intended internalisation for the purpose of control through self-monitoring (Lorentzon 1990; Foucault 1977a) was recognised and resisted (Foucault 1977b).

In effect, participants rejected a conception of knowledge as either/or (e.g. rational *vs.* intuitive), and replaced it with both/and, so working to ostensibly

competing alternatives, which they would hold as valid at the same time (Foucault 2000). In articulating the complexity of this, several participants became aware that to the outsider (or to me, an insider, but from their point of view probably a rationalistic one) this would appear to lack coherence. For most this was the first time they had tried to articulate their understanding deliberatively, so that where they had assumed a relatively straightforward procedure, this was revealed as much more fluid and complex than they had previously understood. This very point was made by May.

May: … It's really difficult, this – it's not as easy as I thought it was going to be! 'Cause you've got to think!

The process of evaluating student performance might be described as a form of juggling: practitioners need to keep several items in the air, items of different size, weight, shape, texture or significance. The responses illustrated in the last chapter, together with those to be highlighted here, tell us that these practitioners are very aware of the intention that they should measure, and see, practice in a particular way. The data also indicated an active attempt to circumvent this by a kind of sleight of hand when articulating these judgements. The claim that dispositional qualities were the key, in contrast to more concrete criteria, would be difficult to reject, especially when presented alongside the notion of caring-ness as the core of nursing work. At the same time, technical gains were said to be important, but were usually regarded as evidence of appropriate engagement with clinical learning opportunities, which, in turn, illustrated caring for and about people in its widest sense. In articulating the process participants constructed a complex discourse around different aspects

of practice, bringing together an overarching, multi-faceted view of practice and a complex view of what it means to claim to be a nurse: the juggler's discourse. This was orientated to their own interest, and allowed them to position themselves in relation to potentially incommensurable understandings. That there might be co-existing discourses in operation is consistent with Foucault's use of the concept: he argues that several discourses can operate in parallel, constructed by and in the interest of different groups, with elements of each possibly found in others, though used for different purposes (Andersen 2003; Foucault 2002a).

The practice knowledge claimed by participants circulated around and within a number of aspects of good or acceptable practice, composed of a variety of facets, and woven into their understanding of what is involved**.** Understanding here refers to the territory of nursing practice – the kinds of things one might expect to find there; it is not suggesting that nursing is definitively either this or that. Practitioners were simply utilising more of the possibilities available to them in the field of immanence belonging to nursing as they saw it than the official discourse would allow (*cf*. Deleuze and Guattari 1994).

Learning nursing

Practitioners made claims about the dispositional qualities they were seeking in students. Disposition as described was concerned with a person's overall approach to learning about nursing. The last chapter showed how attributions of appropriate disposition were foregrounded, while absolute achievements in knowledge or skills held the status of evidence for the latter for these

participants. What was said to matter was, firstly, what a student did with learning opportunities encountered; and, secondly, what s/he did to remedy any deficits which they, as mentors, or the student in her or his own right, had identified. Certainly there was an expectation that the student would be more capable by the end of a given period of experience than at its commencement; but achievement was dependent on the desire to be involved. The absence of particular elements of knowledge or skill was not of itself critical to success by this account, a position at odds with the requirements of formal assessment documentation, which was in turn regarded as a source of ideas if self-motivated development was not evident.

The way these ideas were presented tells us that these practitioners considered that they had the qualities they were looking for, otherwise they could not claim the authority to make such decisions about others. They were looking for evidence in students' performance that they were occupying certain ground, situating themselves in the same territory as the practitioners (*cf*. Deleuze and Guattari 1988). This was couched as a desire to be in nursing (illustrated in the last chapter by Marje, Molly, Rena, Megan), and was manifested as wanting to be there.

Maisie: … when I asked him, you know, what …what his aims were, objectives for the placement, he'd got them in his mind before he came on to the ward, really. He'd done quite a little bit of background…

Given that the emphasis here was not on absolutes of achievement, but on spontaneous, active engagement and attentiveness to learning opportunities, it invoked the image of a more natural display of desire to be with, or of interest

in, people, than was evident in the official representation of practice. Megan, for instance, made extensive reference to one of her former students.

Megan: I think you, yes, you've got to be interested in people … I have seen students, and I think, you know, they'd be better in a laboratory doing research! … because they just don't have those people skills…They're highly intelligent people, but they have no social skills whatsoever … we all have skills in different things.

This natural quality, implying something brought to learning by students, rather than taught to them, was also emphasised by other participants, for instance, Marje, who stated,

Marje: She was a natural communicator; she was relaxed around myself and colleagues.

Reading such qualities in this way implied a concern with dynamic presence, epitomised by desire, which would lead the student to be active in learning. Toni commented,

Toni: Some students think that, because they're actually on the course, that proves that they want to be a nurse. And it isn't.

A few moments later, speaking of the good student, she said,

Toni: And they are eager and they want to learn, and they're asking questions continually.

The reference was quite clearly to the personal desire to know nursing, by engaging with a range of opportunities. Megan continued her own point from above, and moved on to emphasise this perspective.

Megan: I mean they've probably had to try nursing – if you don't try it, you know, you're not going to know, are you? And I think we have a duty to tell these students…

This statement was claiming that certain people are simply not suited to a career in nursing: this disposition is not something that can simply be acquired through training and education. The point was supported quite explicitly by others. Nan, for example, suggested that the purpose of training was to develop technical ability. Personal qualities are brought to the project, and have to be there to make a difference in practice.

Nan: I don't think it's all, in everybody. I think it's in people's personalities as well. So you may not be able to train somebody to be a good nurse…

The notion of duty or obligation referred to by Megan will be revisited in a subsequent chapter, but for the present the function of her statement was clear: she was concerned to show compassion; and she stayed with the dispositional criterion as necessary to learning, resisting the technical end-point model. Her description of the young man referred to (the same one she suggested would be better suited to laboratory work) pointed to the likelihood of his being perfectly capable of undertaking technical aspects of nursing work, and to match this with appropriate knowledge, but she judged him to be failing. Megan's and Nan's descriptions were similar to that given by Nina when she commented,

Nina: You can have the most knowledgeable person, but if their attitude is appalling, then I'm afraid skill and knowledge mean nothing to me... absolutely nothing.

This view implied that knowledge and skills were important; but it was also consistent with the ascription of acceptability based on disposition. Participants' statements pointed to a constant awareness that individual disposition may not entirely or adequately explain omissions in performance; equally, technical criteria were considered inadequate as a basis for judgement of overall satisfactory development. Practice was understood as comprising a more subtle form of activity than technical reproduction or deployment could capture.

The process of attribution indicated what constituted appropriate evidence of suitable disposition, but this appeared now to function as a statement about the *kind of person* thought to be suited to nursing as a career, and about the process of coming to know what nurses know. These practitioners were distinguishing between someone going though the motions of training for a job, and the preferred natural quality of wanting to be a nurse: the beginnings of a model of the nurse, a move in the gradual construction of what would become a multiple and fluid nursing self. From a Foucauldian perspective, these were regular statements appearing throughout their descriptions of the assessment process. The different terms they used, and the way they constructed their declarations about acceptability, came together to express both the kind of thing sought in students, and their understanding of nursing practice: this is "the enunciative function" of such statements (Foucault 2002a, p. 99), found in the relations between them and the "spaces of differentiation" to which they refer (*ibid.* p. 103).

Contradictory practice

A view widely expressed amongst participants was that skills and procedures are easily learned. In chapter four I showed that several participants made reference to the possibility of teaching technical skills to monkeys, to convey their understanding of the non-sophistication of this aspect of training. The claim was striking given the strong emphasis on the competencies-based approach of recent policy; there has even been a call for greater use of practical skills laboratories (UKCC 1999). For these practitioners skills development was something that would come as the opportunity arose; it was not definitive of practice or capability. In the same way, the claim was made that knowledge *per se* could be acquired through exposure to opportunity combined with actively following up any guidance offered. For instance, when describing a student's response to knowledge input from her mentor, Bron stated, emphasising the dispositional once again,

Bron You can give them as much information as you think they need. But if you're getting no response back from them, then you think, why am I bothering. I'm wasting my time.

When asked whether this had to do with acquisition of a defined bank of knowledge and whether this was important, she was clear that failing to understand something could be corrected, and was therefore not critical.

Bron Because you can correct something wrong, or… you can build on that knowledge.

Technical definitions are evidently too limiting on this account, though this is not to say that technical ability does not have its place. For these practitioners,

there was considerable difficulty in identifying a unified model of practice. Megan, for instance, repeatedly returned to the problem of deciding between technical and dispositional criteria to determine acceptability. From the outset of our conversation she made reference to apparent contradictions in the process, *ergo* in the business of characterising nursing and nurses. She readily commented on her uncertainty.

Megan: Now, having said that as well – I'm quite contradictory to myself – but there are some students who will ask all the correct theoretical things, but…

Her reservation about such a student concerned the overall approach. Later she found herself struggling with the principle of standardisation, of looking for particular traits in students as people, and once again illustrated her juggling skills. Following this line of constant contradiction, in the next two passages she illustrated, first, rejection of the idea of a standard personal profile for nurses, and, second, the impossibility of finding all required elements of an assessment without there being some contradiction in the search.

Megan: Because we're all individuals as well, aren't we? And I certainly wouldn't want clones – I really contradict myself, don't I?

Having herself rejected the idea of competence as the reproduction of a set of given criteria, she then returned to it uneasily. Like many others in the group she also used a lot of language of emotional judgement, e.g. "if I felt that…". She illustrated the complexity of her nursing self when responding to a question about the relative importance of the need for a student to produce a particular performance ("come up with the goods") as opposed to showing appropriate

disposition. It was quite clear here that she was not operating to a singular definition of what it meant to claim to be a nurse. The passage is quoted at length to illustrate her difficulty; indeed, her responses were repeatedly punctuated by this kind of hesitation as she wrestled with her discomfort at the realisation that there may be no definitive model that she could use. For someone with her length of post-qualification experience, this was all the more striking.

Megan: … strangely enough… if somebody didn't come up with the goods as well. See, this is how you contradict your… you know, we're very contradictory, nurses, aren't we? I suppose. Or people… but, no, you see, if they don't come up with the goods, that's it. That is true enough, yeh. You think, "Oh, no, I can't…". Having said that, again, they have so many good qualities, but it's this willingness to learn, yeh … *[lengthy pause]* … that would come down… Right! That would come down if I genuinely felt that it was, they just couldn't, did not have that ability to increase their knowledge. Yeh? They'd find it really, really difficult – academically again now…So the academic thing does come into it. Cor! I had to think hard about that. And yet you're doing it all the time.

This orientation to a model of practice not dominated by technical or procedural considerations, and in which the individual brings certain appropriate characteristics to the work, seemed to be built around a notion of caring, although this was never defined closely by anyone. Repeated references were made to a caring profession, caring for others, always implying sensitivity to others' needs.

Competence

Closely interwoven with this unsettled understanding of practice was a view of competence. Participants distinguished between good practice on the one hand and minimally acceptable – or what some called competent – practice on the

other, as well as between acceptable and failing practice. In this, practitioners viewed skills and knowledge as (relatively) easily taught, and technical definitions of practice as too limiting, and caring as something not easily acquired in the classroom. Accordingly, the acquisition and deployment of easy achievements constituted minimally acceptable practice – mere competence; good practice comprised something additional – personal commitment, engagement and so on – that students must bring to nurse training, and which developed further through active immersion in practice. No-one suggested that knowledge and skills do not have a place; rather, these do not dominate conceptions of good practice. This stance has its own logic given the defensive deployment of such criteria to be illustrated later in the chapter.

Nan made the point with some difficulty, that good and competent (adequate) should be distinguished. Her view, that competence is a narrow, technically defined state, was typical of the whole group.

Nan: But I think I would probably say somebody's competent based on my observation of them performing a skill to a … high standard or a recognised safe standard…

Nan: You're ticking the criteria 'Can the student do a care plan, yes or no?' 'Have you watched them do a care plan?' So it is a lot of the mechanistic things.

Between these two statements, at different points in the interview, Nan emphasised that she was more concerned with identifying good practice than identifying technical ability in isolation, repeating this point throughout our conversation. She wanted more to be included in her judgements than was

available through official record forms. Her next comments performed the enunciative function, to establish the preferred understanding, pointing to and rejecting the visibility criterion of the current policy orientation, when she commented,

Nan: Put it this way, I've had, or I've met, nurses that are very safe practitioners, but I don't think I'd want my relatives to be looked after [by] them, because I don't think they've got any caring aspects.

… I couldn't fail them, because the criteria isn't arranged in such a way that you're taking in those … those aspects. I don't feel, that the criteria is arranged like, because it's probably more based on … erm, activities that a nurse does.

Another kind of movement around the concept of competence was evident in another participant's responses. Nerys offered apparently conflicting versions of what she was looking for. On the one hand she considered competent equivalent to safe in terms of correct technique; this seemed to be equated with appropriate knowledge and practical skill.

Nerys: If I say that somebody's competent, what I would be looking at is that they are safe … in what they're doing. They know what they're doing, they understand what they're doing. And, erm…that they have [*sic*] able to do it, in a safe manner that isn't causing any harm, erm, to the patient. That, I would say, is when they are competent in doing something.

Very shortly after this she returned to the issue, suggesting that, while it was important that, if a nurse is to do something, it should be done correctly, nonetheless it was willingness to remedy deficits that was equated with competence. Nerys was also juggling with the proposition that nurses need to be knowledgeable and skilled, while at the same time claiming that lack of

either does not equate to incompetence: a deficit can be remedied, and of itself does not mean incompetence. Hence, she was depicting competence as a different order of achievement than the presence of a task- or knowledge-based criterion.

> Nerys: For …you to be competent at a skill, you've got to be able to practise the skill, and deliver the skill, and be seen that you are doing that in a competent manner. Your knowledge, your competence of knowledge, in my book, I think that… I don't know everything, and I've been a nurse for many years, and I don't know everything. But that doesn't mean that I'm not competent. … I am…I would say that I am a competent nurse – if I don't know something I'll go and find out.

For these people, then, competence was conceived of more as a global attribute than a specific, skill based one; the latter was readily defined by all as competency in something, seen as a locally determined, task specific achievement, rather than as a representation of nursing-competence. Given what participants said about skills, this was a low level achievement, referring at best to minimal acceptability in practice performance; it was heavily based on technical ability, rather than on what practitioners viewed as a complete concept of nursing. Their own model was reminiscent of Deleuze and Guattari's (1994) field of immanence, where all related conceptual possibilities are located, and where none dominates the picture, each drawn on according to situational need. Global competence included technical correctness in situations with which students came into contact. That is, it left the non-achievement of particular skills outside the boundary of competent practice, but not *vice versa*. That the absence of particular sets of knowledge did not of itself imply incompetence was a widely expressed view. May summed it up.

May: … Just because you may be qualified twenty-odd years, it doesn't mean that you know everything, and you're always gonna come across…I always tell my students that you've always got to ask. Don't think, don't just presume that you know what you're doing. If you've never done the task before, you ask..

Safeness

It was no surprise in this context that safeness was an important criterion, and there was no question that it was sought by practitioners. What was interesting, indeed striking, was practitioners' construction of the concept. Standard representations of safeness are concerned with correct understanding and deployment of skills and procedures. This is the purpose of competency statements and protocols, adherence to which is seen as safe practice, and there was evidence of this kind of awareness in participants' responses. However, participants demonstrated resistance to this conception of safeness; for this group at least, it was described as dispositional. I showed in the last chapter that it was the tendency to check prior to acting that was used to determine a student's safeness, not correct procedural ability *per se*. Within their own discourse there was considerable movement between the two, as I will illustrate below.

They could not ignore the official version, and appeared to align themselves with official demands, by acknowledging that nurses need both knowledge and skill. However, in doing this they utilised a range of visible – knowledge- and skills-based – behaviours as evidence of appropriate disposition, and juxtaposed safeness and the need for future continuing development of knowledge and skill. In Deleuzian terms (Deleuze and Guattari 1988)

practitioners appeared to be attempting a recovery of the territory of practice from policy makers and managers, who have sought to take it over for the purpose of measurement and accountability. In doing so, they recaptured the territory of practice by locating the technical element within their *own* understanding of what made a good nurse. So here was a form of transgression (Foucault 1977b) – a struggle with what is discursively permitted – in which practitioners' definition of safeness at work was at odds with the official version.

This view of safeness distinguished the safe practitioner from the safe (i.e. correct) procedure, and was strongly linked to their more global understanding of the notion of competence. It was based on statements about the qualified practitioner: the need to acknowledge a deficit, and then to do something to remedy this. May spelt out, very early in our conversation, that, for her, competence revolved around safeness, but this was not the same as technical prowess. She expressed this in terms of disposition; asked whether a skill deficit was an important factor, she replied,

May: No, because they'll learn to do it. It's when they think they can do things – when they go away to do a procedure, and they, you know, they're thinking they can do it, and they've never done it before – that concerns me.

A while later she developed this.

May: No, a competent nurse to me, if I look at myself … I think … it's …it's being a safe practitioner, it's being safe. It's knowing that what you're doing is the right way to do it, doing it correctly, and if you don't know how to do something, you ask. You find out, er… That to me is a

competent nurse

In the following extracts Grace showed considerable movement at the boundary of what is currently discursively permitted (*cf*. Foucault 1977b): she seems initially to prefer a dispositional understanding – unauthorised territory; then she offers a more technical view – discursively permitted.

Grace: Yeh, that's paramount really **–** I suppose it's that they will acknowledge their limitations […] and… they're keen to … work on them, to…develop their skills

…well, yes, really, to get it right safely. Yes, yeh, and I mean, or at least … allow me to talk them through it to a certain extent. I mean, obviously …or at least tell me, step by step, perhaps.

She was once more juggling, struggling with different conceptions. The contrast between "get it right safely" and "at least…to a certain extent" shows considerable uncertainty about what she can say, having established the more dispositional understanding initially. Grace's construction is fundamentally problematic and requires a more fluid understanding than is implied by fixed, technically driven statements of achievement. Indeed, if these ideas can be held simultaneously, then they are more in keeping with Deleuze and Guattari's (1994, 1988) notion, wherein all associated aspects of knowledge occupy the same space, and non-linear, rhizomatic connections link ostensibly incommensurate elements. This kind of understanding seemed to be present in these practitioners' thinking; fixed definitions gave them another juggling challenge, since these conflict with their concern with initiative and engagement, a point captured below by Bron. The subsequent extract from Nan elaborated on this, illustrating the difficulty involved in such judgements –

balancing self-awareness, willingness to ask for guidance, and confidence, as well as correctness when actually carrying out a procedure.

Bron: Because they can be enthusiastic and not be safe.

Nan: … what I class as a good student, they'll be confident, but they'll know when not to attempt to do something out of their limitations… […] I'd be quite happy for a student to come up to me and just say, "Can I just check this out with you, to make sure that I am doing the right practice?" before they go off and use their own initiative. I mean, it's a bit of both really.

Nan developed her view further, exposing her clear variance from the official technical version of practice: she equated the latter with mere competence – necessary, but not equivalent to good nursing. The general thrust of our conversation suggested that if a student did something, s/he should do it correctly, but did not suggest that this of itself made a good or competent nurse, at least not in the more global sense. Here again a distinction was drawn between the satisfactory (competent in technique) and the good (globally competent) practitioner.

Nan: … if they'd achieved the… performance level and it's safe, then I couldn't fail them, but I wouldn't … wouldn't give them a wonderful report, 'cause I wouldn't feel that they had the attributes to bring to the job.

Indeed, this shift in focus was commonplace amongst participants: they frequently moved away from the question of what made a student's performance competent (according to their own definition, that is) and towards what made a student a good becoming-practitioner. On this evidence, then, it did not matter whether a student could carry out particular skills correctly, or

whether s/he knew and could correctly give a particular theoretical rationale. This of itself would not constitute safeness; instead, especially when accompanied by overconfidence it implied failure to recognise difficulties in what may look like a standard problem. Lack of experience could lead to inappropriate application of, say, a particular procedural skill. To be safe was said to mean confirming the interpretation of a situation prior to acting on it, and taking advantage of any opportunity to develop better understanding and ability.

Knowledge and expertise

The way these practitioners constructed the knowledge base of their practice, then, challenged the given view of practice, and was illustrated further when practitioners talked about professionalism, grounded in ideas of mutuality and patient involvement, active engagement in building nurse-patient relationships, and ethical, confidential practices. There was a constant tendency to refer to good practice through reference to non-technical aspects of professionalism focusing on the nature of the relationship with patients (i.e. the manner of doing nursing). Once again this was based on evidence of personal interest in others, and sensitivity to their value as people, or to their vulnerability as patients.

Abby: And it's really important that they've got good listening skills, and that they can do an assessment of the whole person. Especially when they're doing things like rehab, and … seeing patients as individuals not just as another patient.

Sandy made the point quite clearly that sensitivity and concern for the other was a key element of good practice, and should not be overwhelmed by

considerations of technical prowess. In the following extract she recalled her own training experience and judgements of others' performances.

Sandy: …technically they were good, if not better than good, but just their attitudes did nothing to help the … process of, whether it be healing or, whatever. I think it is so important, because most patients are vulnerable. By the very fact that they're going for treatment for whatever, they're in a vulnerable position. I don't mean you want somebody who'll sit and cry with you all day – sometimes you need a strong person – but you need a person who can at least try and reach out to you.

For many of these practitioners their understanding of the nature of practice showed a preference for flexibility, consistent with the literature reviewed in chapter two (e.g. Wade 1999, Ohlen and Segesten 1998). Indeed, the following extract is interesting for the very fact that Abby rejected a consideration of competence in favour of being good at the job, which was then characterised by flexibility and adaptation, not by adherence to a pre-determined technical standard.

Abby If I'm thinking of somebody who is good at their job, rather than competent, I would think of somebody who is, professional, and organised, and doesn't get phased by things that happen. You know, they can go with the flow and they can … deviate from their prescribed course without it causing them too much of a hassle.

These practitioners were concerned with the nature of, and means of acquiring, nursing knowledge, within which appeared the claim to specialist understanding. This was built around the claim that knowledge and skill development were inseparable from personal engagement with opportunity and with people, and highlighted the manner of their coming to know what they know. Participants displayed considerable ambivalence when trying to locate

formally theorised knowledge in practice, a tendency comparable to the findings of Fish and Cole's (1998) work, in which they found respondents deferred to a personalised form of theory in practice.

Perhaps the most striking example of this was found in Tina's debate with herself about the idea of gut feeling. In this she was pushing against the policy emphasis on evidence based practice. The current policy drive, and her own efforts to obtain a full degree in nursing, on-going at the time of the interviews, pushed her towards finding solid theoretical evidence for any judgement. Yet she also had a certain belief in the value of intuitive knowing – expressed for her as gut feeling – which she articulated as somehow knowing something to be the case, even though the evidence was not always clear. She made an unsolicited reference to gut feeling, which remained at a superficial level initially. Because it implied a particular way of knowing, I asked her about it explicitly in a second interview. When the issue was raised, her response was instant.

Tina(2): *[Immediately]* I'm glad you've said that, because, I must admit, since you, and I thought, I'm glad you mentioned that, 'cause that's bothered me. Gut feeling's bothered me for ages now … because I believed it when I said it! I do believe that there is some gut feeling – I don't know, it's not normal is it, some sort of normal thing when you're having a gut feeling.

Tina continued her wrestling match for some time, to-ing and fro-ing between intuition and rationality – moving to and fro at the boundary of what is permitted – and could not easily resolve this tension. Ultimately the two appeared to co-exist as uneasy bedfellows (*cf*. Francis 1999, on nursing and post-modernism),

with different applications according to the problem to be addressed. Thus, her expertise could accommodate two kinds of knowledge, although she felt the pressure from the prevailing discourse to provide a rationalistic explanation for her judgements.

Tina(2): I would say it to myself – my gut f… - and then I've got to work that out. There's got be a reason why that gut feeling is there. You can't just say, "My…oh, it's my gut feeling." You've got to, there's got to be a reason in there, and when you start putting the reasons down, you start backtracking…

But that's not a gut feeling is it, that was knowledge that was put in my head to go and do that. I can't turn round and say my gut feeling was to do CPR on that patient; it wasn't, it was the knowledge in my head.

This embodied way of thinking was matched by others in the group, with frequent references to 'feeling that…' rather than 'knowing that…'. Another participant who was interviewed a second time, when asked how she would justify her decision (to college staff) if she were to fail a student, offered the following explanation, in which she deferred to her own understanding of the demands of the clinical setting.

Mena(2): … you know, if I feel, and I've got valid reasons, erm, I don't really mind the fact, if they come back to me, and ask me as a mentor, why I made that decision …

Once again, it seems important to acknowledge the language used in this kind of statement – used frequently by Mena in both interviews – to express the idea. The reference to feeling knowledge may be a personal style of speech, but also appeared to serve to articulate observations which defied rationalistic interpretation. That this was found elsewhere in the group is illustrated in these

three short extracts from the conversation with Marje, in which she claimed to recognise suitability by feeling it, and soon confirmed the validity of this way of knowing by tying it to a patient's view of whether someone is responding appropriately. The first two comments were stated early on; much later in the conversation she returned to this intuitive view of knowing a student when recording her judgement.

Marje: I think just being there, that you can feel they're natural…

> And a patient will know… will feel whether the nurse is interested in them…erm… whether they're listening to them.
>
> And I do try and word it in the way I feel it.

Like Mena, Marje chose deliberately to change the words used, from knowing something to feeling it. These comments turn again to the non-technical understanding of professional practice, and a non-rationalistic view of the process of learning about nursing; it invoked an image of the student as an active agent, not merely someone to whom things are done or given. The tension between the disciplinary formation of the aspiring nurse (*cf*. Foucault 1977a), exemplified by the demands of formal assessment, and a nurse's self-constitution as an active practice, not merely the internalisation of others' preferences, showed through. This is a grounded, not an abstracted, rationalistic kind of knowing. Finding the balance between the two was not easy, but such responses were typical of how these practitioners claimed to know their work, and was matched by the continuous return to a more personalised understanding of acceptability (*cf*. Fish and Coles 1998).

Self-defence

Potter (1996) has shown that the way people express their ideas does certain work for them, and this provides another useful perspective on practitioners' claims. When considered in the round it was evident that there was a defensive function in the way judgements of students were expressed. For example, Stella seemed very mindful for most of our conversation of my position in the educational field of practice, and of our relative status – in her perception – despite all assurances that no judgement was being made by me. Her initial responses seemed to confirm this, in that she spent a considerable amount of time showing that she was doing things properly. This conveyed the impression that she wished to avoid blame for any failing on the student's part; her responses were strongly indicative of her sense of being under surveillance (*cf*. Pask 1995; Foucault 1977a), in that she made repeated reference to notions like standards, sometimes explicitly, sometimes implicitly, as here, well into our conversation.

> Stella: … I still wouldn't be happy if…if they were still continuing to work shoddily, and not wash their hands, and… No matter how much knowledge they could give me and feed to me, if that performance wasn't marrying up with the theory that they were telling me, I'd be even more concerned, I think.

Standards of achievement were generally illustrated in terms of knowledge and skills – the measurable aspects of practice. However, when asked to expand on claims that skill and knowledge *per se* mattered more than other things, it was interesting that the majority of participants retreated from any absolute claims on this. It became clear that the specification of knowledge or skill as clear-cut

was problematic, and the emphasis changed through our conversations to a concern with a more general and active orientation to learning about nursing. Several stated readily that technical skills were something that could easily be learned, so that this was not an important criterion for acceptability, except inasmuch as there was an expectation that, following exposure to any of a range of possible opportunities, students should be able to demonstrate that they had learned from it. The following statement typified the relatively low status accorded to skills *per se* in relation to the totality of nursing.

Sandy: I say to carers, when I interview them, that I could teach a monkey to do most of the techniques but I couldn't teach a monkey to be a nurse… because it's, this is where the person comes into it – your personality, how, er, you've got to be, well you've got to try to be very non-judgemental, about the type of people you look after.

Some time later Sandy made a connection back to this much earlier statement, and showed that she was using joined up thinking; she was concerned with demonstration of willingness and ability to adapt.

Sandy: …yeh – I suppose that's the bit about the monkey – you can teach the monkey to be competent, in that he will do a technique, like putting blocks in a hole. But can you, if you turn the holes round, will he … understand?

Sandy was not alone in making this comparison; another hospital-based participant was dismissive of any priority given to technical ability.

Marje: …somebody who's a good nurse can learn how to give a bed bath – and you can teach a monkey how to do a lot of the skills that we do; or procedures that we perform.

Concerning the importance of engagement with opportunities to develop understanding, and the matter of techniques not yet acquired, two more participants commented,

Megan: …otherwise you give it to a monkey to do!

May: So I'm not worried that they…if they can't …[do something]… if it's a simple procedure like catheterisation – which I class as simple procedure, 'cause I think a monkey could catheterise, right?

This repeated and shared monkey theme was strongly dismissive of technical prowess as a primary concern. Despite initial uncertainty, and an apparent desire to acknowledge the preferred technically orientated version of practice, they eventually came to position themselves as resistant to this. In this case, following Potter (1997) for instance, one has to ask what work these statements were doing for the speakers.

Outcomes for pre-registration training refer to the ability to explain, or to bring theory and research to bear on, practice activity. If this is the case, then practitioners too must be able to demonstrate this quality. However, there was widespread acknowledgement of the impossibility of acquiring all the knowledge likely to be required in professional practice during the course of initial training. Indeed, all acknowledged quite freely that there would always be knowledge which they (as qualified practitioners) had not yet acquired, or become expert in. By referring to the need to adapt action according to one's judgement of the situation, or to remedy deficits by active engagement, they were laying claim to this quality for themselves. They could not reasonably

judge students negatively in the absence of particular knowledge or skills, if they themselves could not claim mastery of all of these. So a student's meta-cognitive skill and disposition, rather than technical ability and mechanistic responding, were called upon.

The point is directly comparable to Anderson *et al* 's (2001) finding, whose participants took active account of similarities between themselves – flaws or mistaken judgements, for example – as observers and those they were observing, prior to making a judgement: they defended themselves against charges of stereotyping or being unjust. Similarly, practitioners in this study were acknowledging inevitable similarities to their students – incomplete knowledge, imperfectly developed skills – but also asserting the justness of their approach. For instance, Maisie's use of the plural pronoun in this extract says that imperfection applies to her and her colleagues on occasions, and that collectively they want to be fair.

Maisie: … we don't get it right every time. So…but it's, providing somebody sort of knows if they've done something wrong…we don't expect them to be spot on, every time…

Thus, their model of practice lays claim to greater sophistication than is represented in predetermined responses to complex problems, which necessarily assume that factors outside of the immediate situation will not play a part in individual actions or choices. They were not worried about their own lack of particular skills or techniques: these could be learned easily as or when required, since, by implication, they already possessed the dispositional qualities emphasised in their observations of others. Such statements

importantly – and logically – defended qualified practitioners against technical deficits in their repertoire. Rena illustrated the point nicely.

Rena: I came into this area not being able to catheterise a male patient; I'd had no instructions on it. I came here as a sister, in charge of the group. Now, what I did was identify that I needed to be able to do this; got myself trained up… I don't think that made me a, less of a nurse… although I'm the sister, the head of the team. I feel that nurses within my team…have more up-date knowledge. And I… I explain this to the students…

Rena was clear that this exonerated nurses from charges of incompetence based on lack of expertise in any given area, as long as they acted to deal with it. The emphasis on active acknowledgement of deficits, followed by suitable remedial action, served to preserve her own integrity and status. Other contributors agreed. May, for instance, developed an involved argument (which was interesting in its own right, since she tended to depict herself as quite unsophisticated!), introducing another angle on the matter.

May: … a competent nurse to me, if I look at myself –…it's being a safe practitioner, it's being safe. It's knowing that what you're doing is the right way to do it, doing it correctly, and if you don't know how to do something, you ask. You find out… That to me is a competent nurse.

The first thing May did was to point to herself as the example, and then describe her responses as a competent [*sic*] practitioner. An interesting aspect of this was her reference to being safe. The reference to "knowing", followed immediately by the need to remedy any identified lack of knowledge, was readily understood as being aware of what she knows, and of when she needs to increase her knowledge base. Taken together this illustrated the nature of her response set, and was consistent with the earlier illustrations of safeness.

The value of disposition as a key criterion was confirmed, when she added, emphatically, but – with little doubt – defensively,

May: Owning up to your mistakes, as well, not hiding them…to know everything isn't being competent…

She and her colleagues were now not culpable for any omissions; humility and active remedial responding mattered more.

From another angle, self-defence could be seen in claims for adherence to the official standards for practice. Most participants referred to the official requirement to demonstrate a sound knowledge base and level of technical proficiency. For example, for a substantial part of our conversation Stella maintained an emphasis on knowledge *per se*. Talking about one student who had clearly impressed her, she commented,

Stella: I've had one, this is going back a long time ago [really] – she came back, and she had a lovely file of up to date research on wound care. That was lovely to see, that. And we were able [K Had she read it?] to discussed it and talk it *[mutual laughter]* – well, I hope she had: she was quite knowledge[able] … she's done OK.

What was interesting about this comment – not typical of the way others dealt with their concern with knowledge – was its emphasis on the collection of things to represent knowledge. Although this could have been interpreted as evidence of activity in looking out suitable research papers, she did not opt for this explanation, but left it instead as an impressive achievement in its own right. Stella was looking for some visible evidence that knowledge had been acquired for all that this took the form of a file of papers. She seemed to be falling in with

the prevailing demand for visibility or measurement; and in this she seemed concerned with how *she* may be judged, in light of the fact that I was known to her and located in the educational establishment – for her, probably the official presence of standards, part of the panopticon of policy implementation.

In relation to this concern with her own standing, it was noticeable that Stella made emphatic and repeated reference to factors pertaining to status, e.g. possession of a teaching and assessing qualification to enable her better to carry out the role of student mentor. She seemed to see herself as under surveillance, evident through the paralinguistic and non-verbal elements in her responses. While she presented herself in a way that implied she had a greater understanding of what was needed to learn about nursing practice, this was for the most part portrayed in technical-rational terms – mere compliance with the dominant discourse of practice. Her apparent need to display herself as a good mentor and model to students came through very strongly.

While Stella defended herself by foregrounding technical knowledge, Nina performed the same task by emphasising the dispositional qualities at the forefront of her judgements. Knowledge was acknowledged but ostensibly less important than other qualities.

Nina: You can have the most knowledgeable person, but if their attitude is appalling, then I'm afraid skill and knowledge mean nothing to me... absolutely nothing.

In this statement she was clearly claiming that her own approach to nursing work was as it should be, and dismissing any suggestion that knowledge should

take precedence, no matter how much of it could be demonstrated. Thus, and importantly given the emphasis in her statement, she provided a strong defence against any charge of gaps in her own repertoire. While, in official documents, attitude is acknowledged as important, it is inherently problematic for assessment, and is effectively moved into second place when measurement of achievement is considered. None of these practitioners was dismissing the need for knowledge for practice; they were claiming that without an appropriate approach to the totality of practice, knowledge and skills would not develop, and practice would be incomplete. Both implicitly and explicitly they were also protecting themselves from possible sanctions should they be found wanting in the knowledge and skills element.

The problem of the range and complexity of training demands was brought out by Maisie, when comparing her own training – a more reproductive model – and the present arrangements.

Maisie: ... when we did our training, we knew where we were … they don't have that any more, I mean it's an on-going learning process for them, which it should be for everybody…

She seemed to be doing two things here; on the one hand, she was claiming that current training makes greater demands on students, so *they* cannot capture everything. She was also implying, in her reference to "everybody", that, in the light of current circumstances, she and her colleagues needed to continue to learn. Paradoxically support for this was to be found in the rules for re-registration, as observed by Bron, and was present in several other participants' responses (e.g. May, Nerys, Bron, Grace) in the last chapter. By

tying the claim for the importance of active disposition to learning to future post-registration requirements, the practitioners' defence was quite robust. This stance was in both practitioners' and learners' interests.

Bron You've got to still go on. I mean, you've got, everybody's still got to go on to learn, haven't they? I mean, that's in UKCC and everything else, your … PREP* and […].

Power and influence

The defensive function of the practitioner discourse involved a struggle arising from a perception of possible lower hierarchical status *vis-à-vis* educational colleagues, and from the tension between the competing qualities – from practitioners' own and the regulatory versions of practice – expected of the developing student nurse. The explicit concern, from some participants more than others, with the need to demonstrate personal capability as a mentor-assessor before going on to talk about how they made their decisions about students, supported this understanding. There was, in participants' responses, no self-assured assumption of the right to make decisions without justification. As already stated, Stella and Toni went to considerable lengths to set themselves up as meeting a number of official standards, and thus as having the right to decide on acceptability. Of the latter, my notes made at the time, following a second interview, contained the following comment.

> This is the most extraordinarily pressured talk, apparently attempting to establish her own credibility as an assessor, a manager, a professional. […] Much of the content does not appear to develop the original ideas, but rather to follow her own agenda of determining and displaying her own capability in a number of roles.

* Post-registration education and practice: a requirement for periodic re-registration

Participants' claims worked to set them up as just as capable of determining the case for acceptability as other, possibly more influential, players. However, despite such demonstrations of authority for decision-making, most participants showed reluctance to make a final decision on whether to fail a student. Foucault (2002a) argues that such claims as appeared in the commentaries provided by these practitioners act as statements in the construction of discourse. For instance, in a second interview, Tina showed confidence in her own judgement, but placed the final decision elsewhere, whenever a decision to fail might arise; her contribution and influence would be admitted through a dialogue, rather than that one party should dominate the final decision. She also made clear the practitioner's status in the system.

Tina(2): Well…no, I wouldn't expect them to take my decision to reject it…I wouldn't like them, let them reject it, but I also wouldn't expect them to honour…you know, I would hope it would be a two-way process, and the decision that would come out was suitable … Because their personal tutors – they probably know them for a lot longer than I do.

Although Tina claimed that tutorial staff are better placed to make an overarching decision, since they have known the student across the whole programme, nevertheless she (and other participants) claimed the right to insist on a negative judgement where relevant, since it is a context-based one, even though they may in the end be overruled; Mena observed,

Mena(2): …it's got to be a joint decision really, not just all laid on the college, because they don't get to see the practical experience when they're out [...] [but for] the practical experience of their placement, a lot of the responsibility's got to be on the mentor really.

While this response from Mena may have reflected some uncertainty about our relationship in an interview – we had met previously – both she and Tina drew a picture of the relationship between college and clinical staff as separate, but of the practitioner as authoritative in her own domain; their statements about decision-making performed this function. Toni drew up a similar distinction.

Toni(2): …it's my unit, I'm responsible and accountable for my unit. So I see no other outside influence …And I would certainly say to the college I want this student off my placement. […] If it was that they weren't particularly showing any interest …I would then say, "Right your attitude needs changing, we can work on that". And I would expect the college tutor to take that […] The college tutor really has… ownership of the course – as to whether they're meeting the course objectives, and whether they should be carrying on.

The emphasis was that decisions were made on a context-specific basis, whereas tutorial staff's decisions were more global and from a distance. This in turn implied that they used differing criteria, and thus identified themselves with different values or priorities, according to context. Mena gave an example of a disagreement between her and tutorial staff, in which other-defined criteria were not available, so she had had to rely on personal expertise, and found herself without the winning strategy demanded by the prevailing discourse – lack of visibility.

Mena(2): I was annoyed the college didn't back us up…[…] I did feel if the college would have backed us up, that would have been the end of it then.

As she became more relaxed, possibly recognising no censure was being offered, Mena stated that her experience told her that colleges tend to regard practitioners' judgements as dispensable, when she wanted to meet on equal

terms. She was clear about how she knew this; answering a question revisiting how much influence her decisions might have in final judgements, she said,

Mena(2): …I don't know how much of ours… we don't get any feedback.

While Mena seemed comfortable with the possibility of authority with responsibility, others suggested that college staff *should* have the final responsibility for decisions on students; practitioners' priority was ultimately towards patients' care, as illustrated by Toni's extensive exposition in her second interview, where it became quite clear that her role as educator-supervisor was secondary to her clinical-managerial one. She commenced our second conversation with a lengthy exposition of the local protocols and procedures, which would guide her role in charge of the ward. Much later she returned to this theme in relation to a student who was proving difficult.

Toni(2): … if we're saying, "Look we're having hassle here with this student…" - it's hassle that we don't really need, because we've got patients to look after, and they come first […] because when you've got your ward nurse's hat on, you have to think of your patients. […] So your tutor hat is on as well, but …it's falling off, because you've got other things there.

Whether this was a matter of uncertainty in her sense of identity, or of where her responsibility lay, she seemed to say educational judgements belonged elsewhere. She followed this immediately with another statement which both raised the question of whether to accept learners on to the ward, with all the demands that this made, and served to distance her from the difficulty that others might have. She seemed to want the power to judge students, but without the responsibility for decision-making, though, once more, this may have had to do with her being in conversation with a tutor!

Toni(2): … if the tutor hat starts to knock your other hat off, then it becomes a burden. And … when I say to my trained nurses, "So do you want me to stop students altogether then?"…"Oh, no, I love teaching; I love having a student…"

It seemed that Toni and her colleagues wanted students, but were apprehensive about the threat that this might create to their own position, and the disruption it caused to their day-to-day work. The threat was not from the student, nor from the changes to training and education since they had registered, but from the possibility of making a judgement which was rejected – and so by implication rejecting and devaluing their knowledge and understanding of practice – and the possibility of being held responsible for a student's failure. If they attended to a student's needs at the expense of patients' needs, then they would be responsible and accountable for that failure also.

CONCLUSION

This chapter has demonstrated how practitioners constructed their own multi-faceted discourse of practice, which distanced them from the technical-rational view of clinical practice. Their skilful manoeuvring between the two versions allowed them to accommodate, yet avoid identifying themselves with, the dominant model: practitioners engaged in a form of transgression, whereby they moved around at the limit of what is discursively defined and permitted. They offered a situated view of practice, in which a more flexible understanding was portrayed – and necessary – than is available from the dominant discourse.

Within their own discourse one of the most striking aspects to have emerged concerned the notion of the safeness. There was no dispute about the importance of safeness in practice, but what was striking was that this was not a matter of being able to deploy skills correctly; rather it was a meta-cognitive quality, manifest in behavioural evidence of self- and situation-awareness. Demonstrating humility through willingness to admit a knowledge or skills deficit constituted safe practice. Competence, inasmuch as it was ever referred to explicitly, was associated with safeness, but was presented as a matter of, once having recognised deficits, acting to remedy these; competence and safeness did not equate to the deployment of knowledge and skills *per se*.

The dispositional criteria for acceptability demonstrated in the last chapter also revealed a more defensive purpose to practitioner judgements, and was seen to move away from the relatively rationalistic view portrayed by following a traditional attribution approach. By foregrounding disposition in their understanding of practice practitioners protected their own interest and standing. Their responses clearly suggested that to pursue absolute achievement was to seek to attain the unattainable; pursuit of completion, or closure, would in effect set nurses up to fail. As one participant put it,

May: …sometimes, the sister on our ward will come across things that she's never done before, and she'll ask us.

Finally, these practitioners were engaged in a struggle for influence, which pervaded their experience. While they claimed their right to make decisions about practice on their own authority, this was seen to be undermined by those

with whom they were assumed to be working. At best it seemed that they could offer advice on student progression, and on development and achievement; at worst their advice could be discounted without compunction by tutorial colleagues. For some, there was recognition of the limited opportunity to view a student *in toto*, hence an acceptance of the tutor's larger view; for others, there appeared to be a resignation to the tutor's *de facto* power to overrule their decisions. This issue will be pursued further in chapter seven. In the meantime, the multiple facets of practice will be examined with regard to the constitution of practitioners' sense of who they are as nurses.

Chapter 6: Multiple selves

'If everything you say is true…you must be Canby.' (Juster 1962, p.142)

As the previous chapter has shown, practitioners constructed a disparate and diverse view of their knowledge of practice, but this was an interconnected disparity, sometimes technical, sometimes intuitive, in which different understandings appeared for different purposes. Their understanding demonstrated a rhizomatic, that is, non-linear connection between different elements in their practice (*cf*. Deleuze and Guattari 1988). These elements are inseparable yet variable in nature, apparently incommensurable, but, on Foucault's account, these are contradictions which must not be squeezed into an artificial show of unity (Foucault 2002a). This construction of practice was strongly reminiscent of the Deleuzian notion of fields of knowledge, in which all related possibilities are present, drawn on according to circumstance to guide day-to-day action (Deleuze 1994; Deleuze and Guattari 1994, 1988). Any attempt to redefine the territory of practice for organisational or managerialist purposes, and thus to unify its representation, omits the contradictions and apparent inconsistencies, as well as the unmeasurable, in the interest of an economy of performance at the expense of the ecology of practice (Stronach *et al*. 2002). Within this construction practitioners could roam freely (*cf*. Drummond 2002), placing and identifying themselves within its variability. The analysis now turns to the constitution of practitioners' nursing selves: this account of the data renders it impossible to capture a unitary identity, given the rapid and frequent movement in the articulation of their practices.

The quotation at the head of the chapter is taken from a children's fantasy in which a young boy, Milo, and two travelling companions encounter a perplexed individual who asks if they can tell him who he is. When asked to describe himself, so that they might help, he describes a series of personal characteristics, each accompanied by a change in his appearance to illustrate his meaning: he is as tall as can be, as short as can be, as clever as can be, as happy as can be, and so on *ad infinitum*. After some discussion the three travellers conclude that the strange man is Canby, since he can be anything he chooses to be. His name, of course, locates all these possibilities in the one person: the fantasy has a striking resonance with practitioners' depictions of themselves in this study.

ASCESIS AND SELF-CONSTITUTION

Indeterminate selves

I will borrow the idea of fusional multiplicities from Deleuze and Guattari (1988) as a means of thinking about this; by this term they want us to understand people as fluid and responsive, rather than as a unified, once-for-all, stable identity. Indeed, they repeatedly suggest that people are always in a state of becoming other than they are at any given moment. As with their understanding of acceptable practice, participants were seen to move about on a plane (Deleuze and Guattari 1994, 1988), making non-linear connections to construct and reconstruct themselves according to circumstance. To borrow another

Deleuzian metaphor, they were finding their "Body without Organs…populated only by intensities", rather than by absolutes (Deleuze and Guattari 1988, p. 153). With this concept Deleuze and Guattari propose a version of the self which is unstratified – free from fixity, a result of "fusional multiplicity that effectively goes beyond any opposition between the one and the multiple" (*ibid.* p. 154).

That nurses work with multiple practices has been identified by Stronach *et al.* (2002). I want here to illustrate that this extends to practitioners' sense of who and what they are, and that, by association with the terms they use to ascribe acceptability to students, they project a view of themselves as complex, fluid, and adaptable. In aligning themselves with an alternative version of practice participants performed a considerable amount of work on their own behalf; in describing what they said mattered in student performance they were necessarily describing themselves, or what it is to claim to be a nurse. They were, in Foucault's terms (Foucault 2000), writing themselves. For Foucault, self-constitution does not result in a singular notion of the person: one's identity is an ever-shifting, ever-evolving concept. Participants spoke of themselves as different kinds of people at different times, according to context. For instance Sandy spoke of the need to be strong and directive on one occasion but caring and supportive on another; but she was who she was. Thus, it is more appropriate to talk of *multiple selves*. The manoeuvring performed by practitioners developed their talk into a practice, which was always about something still to come. As Deleuze maintains (Deleuze 1994; Deleuze and Guattari 1994), self is in a state of constant flux. Accordingly what follows is not

intended as a hierarchical sequence; it merely depicts aspects of this fluid self, discernible in participants' accounts. There may of course be others.

This constant reconstruction was probably best illustrated in the marked hesitation displayed by Megan when constructing her answers. She frequently seemed to pose her own questions, of the type, "what kind of people are we?" Indeed, perhaps more than any other participant, her performance was punctuated by hesitations, apparently in pursuit of clarity about her own (previously unexplored) view. Others, such as May and Nan, commented spontaneously that the interview – that is, the process of thinking through what it was that they considered important, and thus how they saw themselves – was more difficult than they had thought it would be. There were, in effect, no ready answers, no fixed sense of what kind of person they were, upon which they could draw in their judgements of others.

It seemed important for Megan to be clear about what exactly she was doing – even though she was never able to draw a single conclusion – when making judgements in clinical situations, as the following comment confirms.

Megan: *[Continuing pause]* It's not a hard question at all – I'm just trying to think how did I…? *[Pause]*

Very quickly, and in one very hesitant statement, the multifaceted – or Deleuzian – nature of nursing's identity emerged very strongly. Megan came to recognise that she used (and expected of students that they should also use) formalised knowledge-skills to underpin her actions, as well as more embodied

forms of knowledge. She clearly highlighted her awareness of this uncertainty, now understanding that both technical *and* dispositional qualities would matter, for different purposes, and at different times, in the person of the good nurse. The following passage was cited in chapter five to illustrate the difficulty inherent in nurses' expertise, but is reiterated here to emphasise the centrality of this in nurses' indeterminate sense of self.

> Megan: …strangely enough… if somebody didn't come up with the goods as well… See, this is how you contradict your… you know, we're very contradictory, nurses, aren't we? I suppose. Or people… but, no, you see, if they don't come up with the goods, that's it. That is true enough, yeh. You think, "Oh, no, I can't…"… Having said that, again, they have so many good qualities, but it's this willingness to learn, yeh … [*lengthy pause*] … that would come down… Right! That would come down if I genuinely felt that it was, they just couldn't, did not have that ability to increase their knowledge – yeh? – they'd find it really, really difficult – academically again now. […] So the academic thing does come into it. Cor! I had to think hard about that. And yet you're doing it all the time.

Moral selves and the other

Such tensions were also present in Nan's responses reported in chapter five, but combined with morality when she emphasised, through her own definition, her preference for good (incorporating a wide range of technical and non-technical elements) over competent (technically adequate) practice. All participants agreed that active engagement, and a show of initiative, was important in their judgements; but this would not be at any cost. For instance, Nan and May made clear that the need to show initiative (a good thing) and safeness (also a good thing) must be seen in context, and considered for their relative good, since they may operate in conflict with each other. This consideration places impediments in the way of ability to make decisions in

assessment. Adhering to one criterion – even one of their own – without a consideration of their broader conception of nursing may lead to an inappropriate outcome.

Nan: …I mean, they might be very keen and feel I want to go and prove this to my mentor, that I can work independently… [But] if it's at the price of the patient, that's what you have to look at, if it's gonna actually affect the patient in any way…

May: Whereas before, on the other ward, I was happy to let them sort of … go off, because there was a routine on the ward, I'm not so happy for the students to go off on their own...because it's so intense, it's admissions – anything could happen

Sandy made a similar point when asked how she recognised competent practice (again, her own definition). She distinguished between global and specific use of the term: someone could be technically capable, but still not good enough. For her, technique was a facet of nursing, but there was more to being a nurse than this. So she was faced with another problem: how to decide? One criterion says yes, while her own says no, to acceptability. It was clearly problematic for her that technical achievement alone could allow a positive outcome. She was thus making a statement about what it is to claim to be a nurse, and how she wanted to define herself in relation to practice, through a complex of qualities.

Sandy: … I mean you can't really, erm, if he passes his exams and what not, you can't really do much about it, but…he's not what I would term would be a good nurse.

I argued in chapter three that there is a moral driver in such open-ended choices (Bauman 1999, 1992; Derrida and Caputo 1997; Deleuze and Guattari

1988). Sandy and others were claiming that nurses have an obligation to act for the good of the other in their relationships. May demonstrated the moral basis of her choices, when she emphasised patients' welfare rather than operational efficiency. Here she wanted students to consider the relative value of different activities.

May: you can't get stuck up in task things, 'cause that's not what you're there for, that's not what you're there to do…You're there to look after the patient – not that your ward's tidy.

As Sandy continued her illustration of this complexity, she revealed different aspects of nurses to be accessed according to the demands of the situation. It is incumbent on nurses to adopt different *personae*: at times compassionate, sensitive, yielding; at others firm, technically and procedurally driven; on yet other occasions, supportive yet vulnerable. Nurses are not, according to this account, compassionate, kind, sensitive as a fixed identity; neither are they practical, or technically knowledgeable in the same fixed sense. The complexity of Sandy's understanding, typical of participants in the study, was captured by a pair of examples, in which there was a deliberate use of her different, parallel selves. First she pointed to the need to weigh urgency against emotional state.

Sandy: …if it is desperately important the blood's done there and then, because this patient could die otherwise, if we don't find a reason – it's gotta be done, even if they're in distress. But if it's something that, well, it's, erm, it's a six-monthly lithium level, and it'll do tomorrow, and they're getting really upset, and that – well, it'll do tomorrow …

Later she showed awareness of individual difference, and that she could not take her prior experience as definitive of appropriate human responding.

Sandy: I mean, it's like, erm, when you've suffered a death of somebody very close to you, you know how you behaved in that situation. You've got to be careful that you don't expect everybody to behave in the same way […] you've got to be very careful not to impose your judgements and your beliefs, and how you behaved, because the way I behave might not have been the right way to have behaved…

These examples are important in several ways, and develop the movement contained in Megan's response. First, they illustrate how Sandy constituted herself through what she knew, and what she did (Foucault 2000). The illustration showed that different and opposing ways of thinking and being were always in her as options. She is always the same person, but chooses, and looks different, according to context. Second, despite having a personal model of responding available, based on her own intimate experience, she showed that she must actively recognise her own position as other, despite the ostensible similarity between the situations referred to, and allow the other to be him or herself. Third, her immersion in the nursing as distinct from the personal situation meant that she could not readily light on one response in preference to another – she must avoid adopting a unitary understanding – because both options are possible.

Accordingly she and others had to choose from a range of possibilities, and choose morally, and weigh these against the particularity – including the other's knowledge and experience – of the present situation. Different options for responding – hence different versions of what it is to claim to be a nurse – are accessed at different times for different purposes. Whether reproduced or reworked, such choices demonstrate the simultaneous occupation by competing elements of the field of knowledge. The equal validity of alternative

versions of knowledge and of self, in contrast to the singularity of the competency-based view, is consistent with Foucault's argument (Foucault 2002a) that certain forms of knowing and being are privileged over others only by virtue of their having been appropriated by powerful interests for particular purposes. What mattered in these instances was acceptance of difference according to context.

The constant movement between different positions was illustrated further in the following comment, again from Megan.

> Megan: …because in the everyday run of things, 'cause you're assessing them all the time, aren't you, all the time you're jumping from one thing to the other.

The absence of a singular, universally applicable view of the nurse renders any situation, other than those which can be technically defined, impossible, since there is no universal understanding of the nurse's self on which to determine the other's acceptability. The imposition of the economic model of assessment and purportedly definitive reference points reduces nursing practice (Stronach *et al* 2002; Derrida 2002), hence, nurses and people, to programmable entities. These practitioners rejected this understanding in favour of morally informed judgement of each situation as it arose.

Contrasting understandings were captured again when Sandy described her own experience, in which she had adopted a more directive *persona* on some occasions but a compassionate and emotional one on others. There was, for her, no contradiction in this. Her claim was that each had its place, as one of

several possible ways of being, but would not necessarily be active at the same time. The same individual can be different things at different times, but is always the same individual: flexibility counts, not adherence to a fixed notion of what it is to be a nurse.

Sandy: you've got to adapt it and find a different way. I think nursing is about flexibility and adapting.

> … When you go into houses and people are dying, the family's with you – it can absolutely break your heart. But you haven't the luxury always – you're there, to do something for them. And then you go home in the car, and you cry the whole way home…

Such a practice, then, offered differing manifestations of self for the individuals involved, written for their own purposes. Practitioners' rejection of the technical as an adequate representation of nursing practice, and by implication nurses' identities, illustrated the possibility of parallel planes, "doubles" (Deleuze and Guattari 1988, p.166) which may mistakenly be substituted for more authentic images when thinking about a practice which incorporates, rather than allows itself to be dominated by, the technical. Participants mobilised subtle judgements to differentiate between desirable and undesirable characteristics in others – "the emptied or cancerous doubles" of the "other plane" (*ibid.*) – given the purpose for which their judgements were made.

Expert selves: ambivalence and transgression

Another aspect of participants' fusional selves was demonstrated by their willingness and ability to work with the dominant technical version. Beyond concern with the importance of context there was an additional concern

apparent in Tina's talk, for instance, focused on the different status of knowledge in contemporary training compared with that of her own generation. Hers was an expertise based on practical know-how with a sophistication derived from years of experience, whereas the new generation of students are more focused on formal propositional knowledge. This seemed to be perceived as holding higher status than she did, raising another form of crisis for Tina. The question of status was pursued in a second interview.

Tina(2): I think it's just because you never get recognised for that… I think it was just that the system has made me feel like that, because you just, they've not respected the people that were already here. They brought all these new ideas but they've forgot about the people that are left there.

She was pointing to the different forms of knowledge available to nurses, and again by implication the constitution of the nurse herself – technically or intuitively orientated, for instance. The re-shaping of one form of knowledge or way of being only implies the development of its articulation over time; it does not diminish its value or relevance – another parallel with the ideas of Foucault (2000) and Deleuze and Guattari (1988). Tina's own background was immersed in practice-based learning, with very little emphasis on the (formal) theoretical. In her account this softer form of knowledge, hence her way of being a nurse, has been lost in the modernist pursuit of the essence of practice – its articulation in scientific terms, clarifying things by reference to the visible and elemental – yet these practitioners seemed to constitute themselves by reference to this softer perspective.

Tina was strongly aligned to a more intuitive sense of self-as-nurse. She had, in her first interview, made explicit reference to gut feeling as a basis for action, and wanted to uphold this way of knowing, but struggled with its opposition to propositional knowledge. As the movement in the following extract showed, this was part of her way of being a nurse.

Tina(2): I don't think I would do that now, I don't think I would actually say, "My gut feeling is this." I would say it to myself – my gut f… - and then I've got to work that out. There's got be a reason why that gut feeling is there. You can't just say, "My…oh, it's my gut feeling." You've got to, there's got to be a reason in there, and when you start putting the reasons down, you start back-tracking, thinking, "Oh maybe that's not quite right, that's not quite right…!" *[Amused by own thoughts]* So I'm back to my original now, I don't think there is a gut feeling.

On the face of it Tina (who was undertaking a 'top-up' undergraduate nursing degree at the time) was being re-socialised into accepting that professional action must be backed up by formal theory, or evidence – others were effectively territorializing her known field of knowledge – but was unsure exactly what this theory might be in many instances. Her judgement of situations was, in her view, appropriate and accurate, based on a kind of knowing that students would have to obtain if they were to achieve similar expertise. Nonetheless**,** her identity as expert has been challenged; she has had to align herself, at least publicly, with the contemporary discourse, despite her difficulty in doing so. However, she explained her reason for this apparent alignment (distinguishing rational and intuitive as professional and personal).

K What do you mean, "Evidence", then? Is that personal preference or is a professional preference?

Tina: Professional! [*Laughs*] 'Cause you get sued left right and centre, if you

[don't have some] evidence, yeh!

Her struggles with the problem of gut feeling *vs*. propositional knowledge as equally valid forms, and her rejection of the limitations of the rational model, showed her transgression of the boundaries of the dominant discourse (Foucault 1977b). Returning within the discursive limit had a protective value for her, and alleviated the discomfort of her transgression. Her tussle suggested that she wants the right to make her own versions of knowledge and self, while acknowledging the range of alternative ways of construing the world (*cf*. Derrida 2002). Within the complaint that her version of knowledge has been demoted is awareness that the current model removes her right to choose, and to inform practice from her own extensive understanding. Quite clearly her acknowledgement of the technical-rational approach had a pragmatic value, rather than being embedded in her way of thinking or being, implying a continuing identification with the alternative. One can clearly see the discursive psychology of Potter (1997) and Anderson *et al* (2001) in Tina's weighing of the implications of the judgement involved. She was aware of the current climate; but this is a view of nursing concerned with organisational liability rather than good nursing care, and one has to protect one's vulnerability. Consequently, Tina and others might claim to formulate themselves pragmatically according to this alternative model, in their own interest if for no other reason. In effect, identification with the dominant preference was just one amongst a number of possibilities for self-constitution: when faced with formal enquiry she was a technical-rationalist; in her own familiar clinical area, she was an intuitive practitioner.

Self as always-becoming-other

The claim that disposition is the key criterion for judging successful development marries well with contemporary thinking about professional practice: new registrants must be orientated to lifelong learning. All of my participants were clear that it was unrealistic to expect all relevant skills and knowledge by the end of the training period, and I showed in the last chapter that this choice had a self-defensive function. More constructively, however, they were simply depicting themselves in a situationally appropriate light. Backed by the current demands of professional practice and policy, there is always and necessarily a need for continued attention to development of knowledge and skills. Thus they constituted themselves as always becoming other than they are; they readily acknowledged that deficits might exist in their own repertoires, but they could still claim that they were capable practitioners.

Nerys: … I don't know everything, and I've been a nurse for many years, and I don't know everything. But that doesn't mean that I'm not competent. … I am…I would say that I am a competent nurse – if I don't know something I'll go and find out.

Rena made a similar point; competence is the willingness to recognise one's own incompleteness and to act to rectify this. It is not an absolute state.

Rena: Now, what I did was identify that I needed to be able to do this; got myself trained up…

Even the most discursively conscious participant, Stella, made no claim to have acquired a complete state of knowledge and skills. Even early in the conversation, when she was concerned to establish herself as a good model by

repeated reference to standards, a determinable body of knowledge, and mastery of given procedures, she was clear that she must continue to develop herself. She openly pointed to her lack of completion, and the need for adaptability according to circumstance.

Stella: Yes, I think it's always, I think every…everything needs to be reflected on – because I'm not perfect in practice, and I do things, and I think afterwards, I should have done that differently...

That knowledge, and the ability to access and utilise it appropriately (*ergo* what it is to claim to be a nurse), is never complete was explained in the following extract. In a model reminiscent of Deleuze and Guattari's (1988) knowledge plateaux, practitioners moved around actively, picking up knowledge from different locations, choosing elements according to their situational relevance, constantly expanding the field of knowledge and re-making themselves rather than refining it or themselves to some essential understanding.

Sandy: you will continue to gain more knowledge, right through your career – it's not something that you learn, and that's it, end of story. You're constantly learning, and as you're learning, it's bringing a new awareness, on top of the awareness you already had.

The final point in this observation is important: that new material is gained "on top of the awareness you already had". Nothing is rejected, or pared down; the field of knowledge is merely expanded, one's identity developed and built on, and new options introduced rather than used to replace others.

The assessment practices deployed, then, imply that practitioners were not concerned with assessing the presence or absence of a state of completion

implied by the achievement of competence, and by this means they were also projecting an image of themselves. They were anticipating the demands on their own and others' future practice, making judgements about something yet to come. Deleuze and Guattari (Deleuze 1994; Deleuze and Guattari 1988) argue that things are never static – even when apparently repeated, they are never quite the same: the same thought, the same action, the same intention, the same entity – and are always in a state of becoming other than they are now. In the process of assessment practitioners are asked to determine whether someone has reached a pre-determined standard, when their preference seems to be to look to the future, a process which involves much more than simple reference to given, static components of a rationalised version of practice. By invoking an assumption that current behaviour will continue into the future, active engagement with learning indicates recognition of this state of always-becoming-other. Where acceptable technique was displayed, or where particular knowledge or attitude was identified, these were regarded, for the time being, as snapshot examples of change from a previous state, or alternatively as a state to which the individual can return when relevant.

CONCLUSION

Practitioners' responses show that the ground on which they stand is continually shifting and reconstructed. This moving around writes and re-writes their notion of a nursing self, which turns out to be a plurality of selves, not an easily captured, singular identity. The frequent connection and reconnection with different points of reference in deploying their judgements sits well with

Foucault's ascetic construction of self (Foucault 2000). Foucault has argued that ascesis operates through self-examination in terms of thoughts, feelings, and actions, to arrive at an understanding of who or what we are. That practitioners moved around looking for different qualities at different times, frequently pointing to themselves as working examples and claiming to act accordingly, projected a view of themselves, in terms of what they claimed to seek in others, as constantly adapting.

For this group of practitioners the actions through which they would be known to themselves and others were never fixed, constantly having to adapt, so the nursing self could never be complete, and would never be identical to others. Achievement of a predetermined state at the point of qualification was not considered appropriate within these accounts. Deficits were not indicators of an incomplete self; they merely implied a need to change beyond the present limit. Thus, individuals would always be changing – practitioners and students alike, and only in this sense were they the same – drawing on a multiplicity of sources and perspectives. The fusional multiplicity of nurses' self offers an alternative to the closed image of a competency-based model: a Body without Organs (Deleuze and Guattari 1988), one in a constant state of flux.

The concerns illustrated in these three chapters – what to look for, their combination as an alternative discourse of practice, how to describe oneself as a nurse – leads to a state of affairs in which judgements are profoundly problematic for practitioners. The next chapter will consider the problem of decision-making *per se*, using insights from Derrida's (1995) notion of

undecidability. What practitioners know, how they use it, and their manoeuvring to deal with the impossible demands made of them by assessment protocols and their multiple selves bears comparison with Deleuze and Guattari's distinction between the virtual and the actual (Deleuze and Guattari 1994), as different ways of thinking the event of nursing (Drummond 2002).

Chapter 7: Decisions, justice and authority

I have shown that assessment of student performance, at least for these participants, was far from the rational process implied by the identification of competencies. Instead it formed part of a complex practitioner discourse, which in turn revealed a number of nursing selves, better thought of as a fusional multiplicity than as any singular nursing identity. Through their own discourse practitioners projected a fluid model of practice and of the practitioner, against which they would judge the development of others. They were also shown to protect their own interest with respect to judgements of students' practice, through their rejection of a complete state of development, implied by competence, as unattainable: they and their students were in a state of always-becoming-other.

UNDECIDABILITY

Consequently a tension arose between guidelines applying to all and judgements of particular individuals in particular situations, rendering decisions about students' progress at best difficult, or, at worst, impossible. Derrida (Derrida and Caputo 1997; Derrida 1995) calls this state undecidability, a condition in which decision-making becomes a hesitant affair if it is to achieve justice. General rules – in this case official criteria for assessment, or even on occasions those from practitioners' own construction – must first of all be recognised and acknowledged; but these must be suspended temporarily, to allow the characteristics of the presenting situation, and the consequences of a

particular decision, to be properly evaluated. Then comes the need to make a decision, which carries the possibility of being right and wrong simultaneously, since it will always involve rejection of either the general rule or the particular individual and circumstances.

In addition, as they articulated the process of decision-making it became apparent that practitioners felt a responsibility to the other in the relationship. This was linked to their perception of their status in the decision-making process: not only were they faced with problems of justice *vis-à-vis* individual students, but they also revealed some uncertainty about their status in the system, hence right to make a decision in the first place. Responsibility to the other provides the starting point for this chapter; subsequently I will deal with the aporetic decision-making process itself; and finally there will be a consideration of the problem of power and authority in coming to a decision, especially where this concerned progression or continuation.

Responsibility to the other

Derrida (1995) tussles with the problem of the other, expressing the problem in the ambiguous phrase *tout autre est tout autre* (p.82, *ibid.*): every other is wholly other, both different and separate, hence never entirely knowable. However, without some similarity to the self or the known, communication would be impossible, and he suggests, again somewhat ambiguously, that the other in any relationship is both known and unknown to the observer: known by virtue of similarities to the observer; unknown by virtue of an inner self, always invisible to the observer. This understanding owes something to Levinas' view

of the other, based on the face-to-face encounter (Levinas 1969). Levinas argues that the face is only ever known superficially, and thus, one is obligated to act cautiously in order to act justly. He wants us to understand that merely by virtue of our encounter with another individual, we acquire a responsibility to that other; for things to be otherwise always implies potential injustice.

Consequently the other can never be judged absolutely. While practitioners were conscious of the need to accommodate professional requirements in assessment – universal criteria implying sameness and knowability – they were very mindful of the problem that this presented in judging individual students, since they only ever had a snapshot view of them: applying criteria mechanistically may not do justice to the individual. Throughout the data practitioners showed a moral concern for the student, and that they were not simply concerned with the technical-rational interest, though this was a part of their judgements. Part of what repeatedly interfered with making a definitive decision, whenever this question was put to them, was the desire to avoid condemning a person for his or her inadequacies in situations which represented only a small part of their total experience. Additionally, there was a concern that there may be other, unexposed impediments to progress, part of that invisible otherness identified by Derrida. The problem was well illustrated by Stella, who was very uneasy about declaring someone unsuitable.

Stella: … because there must be an underlying reason why somebody…

Although she had not yet found one, she *wanted* to find some other reason for inappropriate behaviour. Her ambivalence contrasted starkly with her early

extensive exposition, referred to in chapter five, of the need to promote appropriate standards, provide a suitable role model, and judge performance against these. This had seemed easy to do at the time, at a distance from particular instances, but was now difficult to apply to an identified individual. Despite having spent a considerable amount of time on a technical-rational characterisation of what she sought, she was compelled in the end to make further allowance for a student who was failing to live up to her model of practice. Indeed, she acknowledged that she could not know all about this individual, since she could not explain her observed behaviour; to have judged her unfavourably, it seemed, could be to do the student an injustice.

A more direct illustration of this sense of responsibility came from Megan, who painted a picture of nurses as compassionate and caring, an impression conveyed consistently throughout our conversation. Obligation to the other was nicely captured towards the end of the interview when she emphasised avoidance of condemnation, once it had become clear (to her) that someone would not be suited to a nursing career. Her comment displayed the competing elements quite succinctly.

Megan: …a great brain, but no common sense*. But it was more than that – no, he had no… It worried me, because I certainly didn't want to destroy him, because he came over to me as a very sad, lonely lad in the long term. I wondered if there's things that had influenced [him]…

* This term was defined for present purposes by another participant in Chapter 4 as a function of situational awareness.

As in Stella's comment, Megan was evidently considering the possibility of wholly unknown aspects to the individual, through which it would be unacceptable to dismiss his personhood. However, her understanding appeared to have moved a step beyond simple allowance for unseen circumstances, in that she was clear that this person was unsuited to nursing, but could legitimately occupy some other role. Although Stella had not explicitly moved outside the realm of nursing practice, it was evident that her discomfort was similar in nature.

A further angle on this obligation to the student as other, though this time in terms of the known, in the sense that students occupy the same professional space as their mentors, was brought up by Bron. Students as people may be wholly other, but must demonstrate the same professional attributes as their qualified colleagues. An aspiring nurse must be orientated to continuing development. In chapter five I used the following statement to demonstrate its protective function for practitioners; but it also served to recognise that students, like qualified practitioners, are expected to engage in continuous learning post-qualification, and so must show this orientation from the outset. The comment is from a sequence in which Bron was rejecting the possibility of ever obtaining a complete set of knowledge or skill.

Bron You've got to still go on. I mean, you've got, everybody's still got to go on to learn, haven't they? I mean, that's in UKCC and everything else, your … PREP and […].

PREP requirements seemed to present Bron, and others, with a problem. This view was present in several participants' responses (e.g. May, Nerys, Bron,

Grace), all of which, knowingly or unknowingly, highlighted the paradox of training which could insist on some notional closure by the point of registration, but then tell all that they can never be complete. On this basis, failing a student for not achieving closure would be an injustice in the face of active engagement. It would seem that if this requirement applies to practitioners, then it must logically apply to students as becoming-practitioners.

General vs. local rules

Practitioners demonstrated Derrida's three aporias (Derrida 1995): recognition of the universal rule and its immediate suspension; consideration of the particular situation and recognition that this does not fit easily – arising, amongst other things, from the obligation to the other; and finally the need to make a decision. For instance, having established that compassion was important, Megan would then return to the notion of technical knowledge, as the basis for care delivery and decision-making. However, she returned frequently to what she called basic nursing care – in context, an apparent reference to dispositional qualities of engaging with and caring for people – and was confident in declaring this to be core to good practice. She would then declare that technical knowledge and skills (basic or otherwise) were important after all. She had difficulty in reaching this conclusion, as it seemed important for her to clarify her own thinking on what exactly she was doing when making her judgements. Eventually Megan came to recognise that she used, and expected of students that they should also use, formalised knowledge-skills to underpin action, but in doing so she highlighted her considerable uncertainty about how

definitive this might be: suspension of the general rule in favour of a consideration of the particular. I return once more to her most telling statement.

> Megan: … if somebody didn't come up with the goods as well. See, this is how you contradict your… you know, we're very contradictory, nurses, aren't we? I suppose. Or people… but, no, you see, if they don't come up with the goods, that's it… You think, "Oh, no, I can't…". Having said that, again, they have so many good qualities, but it's this willingness to learn, yeh … *[lengthy pause]* …

This extremely hesitant statement, and through it the fragmentary nature of nursing's knowledge base, showed the problem inherent in decision-making for these practitioners. As Derrida (Derrida and Caputo 1995) would have us understand there is an important distinction between programmable decisions and judgements. Applying a singular perspective to the measurement of student development was impossible for participants; they repeatedly invoked additional criteria according to the situation and the individual involved. Throughout our conversation Megan was concerned with the problem of disposition counterbalanced by technique or knowledge. Both were part of the set of rules, but potentially at odds with each other. Decision-making was difficult if she was to avoid dismissing either the individual or the professional interest. By the end of the interview she concluded that potential harm to the individual, following a judgement of failure, was undesirable. Any definition of competence as an absolute state was resisted, since she (like, for instance, Sandy, May, Rena) regarded technical skills, though necessary to everyday practice, as fairly low level achievements. They were, therefore, in any judgement of acceptability, capable of being suspended in favour of concern with the person.

Tina illustrated another kind of problem in practice. In the following extract, she was trying to decide whether she would insist on failing a student, or would leave it to others to make a final decision. Her difficulty arose from the need to acknowledge that her observations may only be part of a continuing story – in effect, she saw students as always-becoming-other (*cf*. Deleuze and Guattari 1994) – and therefore she was not always in a good position to make a definitive judgement. Within the wider context of training, she recognised the possibility that her own view was incomplete. She wanted to avoid being unfair to the student, and was mindful of the distinction between isolated instances of poor or unsafe practice and enduring patterns of performance in which weaknesses were constant.

Tina(2): *[Pause]* … I think it depends on the situation again. Erm, but … because it's such a short period it might just be a weakness that person has got all the way through. Therefore me telling them [*the college*] is yet another person telling them that this person's got a weakness. Or it just might be that that person's just having a bad 7 weeks, which is, which does happen… so… you know, there's stresses and whatever.

Tina had previously made clear that if a student's actions constituted dangerous practice, then she would have no hesitation in reaching a decision to fail the student. She defined this in terms of deliberate inappropriate action or careless omission, something over which the student would be expected to have some control, and distinct from lack of engagement with learning, say. On the face of it this would remove any hesitation from decision-making. However, where such a condition might apply, then in Derridean terms it ceases to be a matter of judgement, and becomes a programmable decision (Derrida and Caputo 1997).

What makes Tina's assessment of the student undecidable is the uncertainty involved in *judgement* of the student as a developing practitioner; the student's performance over time may differ from the particular instance, and any deficits be remedied. There was, throughout Tina's story, a desire to be just to the student.

This was a common theme, illustrated further by Mena, when she built up the picture of a repeating pattern, within which something also happens to change the nature of the problem.

> Mena: … if I have failed a student… well, you can usually see how it's unfolding really … I mean, every couple of weeks we have a chat and go over things. And I write things down, so I provide the evidence on such and such a date – what they were doing, or how I tried to explain to them really that, you know, that's wasn't on, and they couldn't really do that […] And even if I do see some improvement, but if they're still unsafe – that's the word I always use for this, for their own, safe…people … not, obviously, naming the patient but saying what they were doing with such and such a person, or how I tried to explain, bringing it in that, they wouldn't listen, or that they couldn't understand if you go over it again.

This kind of decision using the universal rule illustrates the distinction between undecidability and programmability (Derrida and Caputo 1997). The safeness premise is that certain actions are unambiguously classed as dangerous, and therefore there is no need for deliberation: decisions are pre-determined, especially for registered practitioners. However, these practitioners are dealing with students at different stages of training. In Mena's example, some identified activity militated against safeness, and therefore was considered unacceptable. However, even here she resisted the immediate application of the rule, allowing for the particularity of the student and the situation. What developed

subsequently was that the student failed to change sufficiently, and to engage effectively with advice. What was especially interesting about this example was that even the technically-based rule of safeness, seen in terms of direct action, was context-dependent. Indeed, Mena made the point herself, that it was not the decision that mattered, but the conditions under which it would take place.

Mena: The context, I think, matters more than the judgement, because you're explaining, sort of trying to get an overall picture as to why, not just the judgement, as to why things haven't quite gone right, or where the problems are…

Whose rules count?

Throughout her conversation with me, Molly spent considerable time setting up disposition as the crucial component of good practice: it was the first thing she lighted on, and she did so with clear enthusiasm for its importance. Thus, it appeared initially to be her overarching model for practice, her own version of the universal rule. Nonetheless, she then showed considerable hesitation using this to judge a student's performance in particular situations: that is, where others would suspend the given rule, Molly was found to suspend her own rule, when the situation in hand demanded attention to the technical.

Molly: … when it comes to things like, er, physiology and things like that - not applying that to their practice. Erm, knowledge of drugs, pharmacology, things like that. You'll sort of sit down and you'll talk to them, and say, 'Well, you know, these are the drugs the patient is taking…Do you understand what an ACE inhibitor is?' … particularly the ones that are degree level, they're doing the physiology at that level, you know they should really understand that physiology.

She now appeared to suggest that knowing '*x*' was important, and was moving away from the dispositional, with which she opened her story. She now seemed

to prioritise a technical version of practice, having passed beyond the dispositional criterion. In effect, she was moving around, like Megan, trying to find a place to settle. According to her earlier claims, by staying within the policy version of knowledge for practice, she would be wrong with the individual; by moving outside it in the situation she had now described, she would also be wrong. In order to render the problem more decidable – more programmable, that is – she temporarily dismissed the preference for applying what you know, even though a short while earlier she was at pains to establish that knowledge *per se* was not the crucial quality sought. Eventually she resolved the dilemma, and arrived at the compromise of expecting particular knowledge in light of particular opportunity: particular knowledge would be important in the presenting situation, which was there to be dealt with, rather like Mena's example above. In response to my suggestion that her focus at that point

> K seems to be more on the level of activity that the student shows in relation to learning about new things … engaging with, with patients, and opportunities … rather than about an absolute state of knowledge … – is that right?

she replied,

> Molly: Yes, definitely, definitely, definitely is. But if I know that they've had that experience, they've had the opportunity to learn that, I would expect them to learn that.

Vacillation between one position and another was a constant feature of participants' accounts of the process of decision-making, finally allowing circumstances to guide what was needed, without deferring to absolutes: technical gains, while important, were context-dependent. As the following

extract showed, while students would need the technical elements of knowledge, they should become more than that, and that is what makes decision-making difficult: as several participants pointed out, technical prowess will keep things ticking over, but practice is more sophisticated.

Molly: … we've got, er, nurse, erm, nursing auxiliaries now doing bloods and things like that. You can teach anybody to take blood; you could teach anybody to do a dressing; but it's communicating with the patient: how does this wound affect the patient? What is the patient's symptoms? How's it affecting her daily life, her activities of living? And that really is what nursing's all about – is improving that for the patient, maximising the patient's potential, and that's what the students should be doing, not just doing a technical skill.

May's story also made the point that acceptability was not merely based on technical achievement or on disposition in isolation. For her, there was a connection between motivation and willingness to be involved and actual knowledge and skill development, which rendered the judgement difficult. Like others, she seemed sure in the end that enthusiasm, whilst crucial, was not sufficient on its own, and that it should have led to some change. The presence of particular, predetermined knowledge and skill was not the key issue – these simply provided evidence that the student *had* applied him or herself. The relationship between the two is a complicated one, involving judgement, not programmed decision-making, according to the demands of the situation, as well as the stage of training of the student. When asked whether motivation without discernible achievement would suffice for a positive judgement, May commented,

May: It's not OK…if they were motivated then… why can't they do anything?! *[Laughs]*

The message was conveyed here, within the laugh, that this was such an obvious point, it rendered my question silly, but it is an important point to draw out. So much emphasis was placed, by all participants, on active engagement with learning about nursing that the initial analysis set aside concern with gains in knowledge and skill. May made it clear that there was an expectation of change, but that this change was dependent on opportunity, not on some preconceived knowledge and skills. Molly had shown the same difficulty in holding the two up to scrutiny, even though this might be for slightly differing reasons. Their judgements were clearly more sophisticated than programmed decision-making (*cf*. Derrida and Caputo 1997). It seems clear that the individual should not be sacrificed on the altar of technical rationality; as Derrida (1995, p.95) points out, “a decision always takes place beyond calculation”.

Safeness: an easier matter?

So far, then, in addition to concern for the person, there were at least two dilemmas which impeded decision-making. First, was the student engaged with learning? If not, yet knowledge and skills were present, should this particular student be judged favourably? Second, was there some change as a result of engagement? If not, yet the student was accessing opportunity and enquiring appropriately, was this sufficient, especially since there may be some development over time? Additionally, judgement of a student’s safeness presented a third dilemma. While practitioners constructed a non-technical version of the concept, based on disposition rather than procedural criteria, the problem was that it is impossible to judge this absolutely. A number of practitioners understood that there was always a degree of risk involved.

Requiring students merely to demonstrate correct procedure, or correct theoretical explanation, was not held as the same as requiring a student to demonstrate awareness that on occasions procedure may need to be suspended or modified.

Thus, safeness was explained as a situated judgement, couched in terms of the individual's disposition. While carrying out certain procedures incorrectly may be unsafe, practitioner enunciations pointed to safeness as the tendency to confirm the accuracy of observations and understanding first, and act later. Once again, the judgement is fluid, and requires the identification of a pattern of behavioural *tendencies* rather than a decision on discrete skill or knowledge. A student may have an incomplete understanding of a particular problem or procedure, yet may still be considered safe. For example, Grace knew safe practice when she saw it, illustrating this as follows.

> Grace: …She was a safe practitioner – obviously, which is paramount – and she proved that to me; … was quick to say when she wasn't happy about doing a procedure, or when she wanted to learn a procedure more competently...

Paradoxically, safeness in this version was demonstrated by the absence of action rather than its concrete presence! What mattered was the tendency to recognise when skill or knowledge was insufficient, and to hold back from acting. The problem with this, of course, is that it runs counter to the preference for the visible; it is more difficult to record. The difficulty of facilitating a student's knowledge and skill development, while protecting others from danger,

inevitably involves risk – another paradox in the face of the need for safeness. Nan made the point nicely with a reference to guarded risk-taking.

Nan: I'd be quite happy for a student to come up to me and just say, "Can I just check this out with you…?" before they go off and use their own initiative… You have to let them do a certain amount of things on their own, otherwise they're not gonna gain that confidence. So it's all, it's assessing that particular individual.

Here she made the critically important point, supported through the ubiquitous reference to the need to discriminate between individual and situational factors amongst participants, that all judgements use particular as well as global criteria. A comment from Megan illustrated the problem of safeness as a technical construction. When asked whether the absence of technical skills was a problem in applying a favourable judgement to someone's practice, she responded with

Megan: … I think you're, you know, people have to have a little bit of humility to say, "Oh, just a minute, I don't understand that." Or, "I don't know exactly how that works."…

When asked immediately following this whether that would mean the student was safe, she appeared to be in no doubt.

Megan: I think it makes them a damn sight safer than somebody *[laughs]* who's going to say, "Yeh, I can do that!"

What was especially interesting about this statement was that, as Grace had implied, paradoxically it was the absence of action, rather than its presence, which demonstrated safeness. Abstracted technique can be tested for accuracy; without a particular context, however, it appears to lack meaning. To

judge practice as safe therefore meant judging an individual's situated performance; to do otherwise was effectively an injustice.

Decision-making, power and authority

For most participants the problem of undecidability for particular situations combined with responsibility to the other. Some also expressed reluctance to accept the final responsibility *per se*, even where poor practice had been identified; though they appeared happy to make definitive judgements within their own (clinical) domain, taking the final decision on progression was problematic. Several (e.g. Toni, Mena, Tina) said they experienced a sense of distance from ultimate decision-making, and spoke of making suggestions or recommendations, rather than definitive judgements, to tutorial colleagues. Two possible explanations presented themselves: colleges were seen to own the programmes, so practitioners experienced a lack of authority to make final decisions; alternatively practitioners were not fully signed up to the modernist model of knowledge, so did not have the authority to decide.

An example of the latter position came from Stella. Although she went to considerable lengths to present herself by association with the contemporary discourse, she subsequently showed considerable reluctance actually to take a decision. Despite her use of approved terminology, she gave the impression that she was not totally committed to this way of deciding on the standard achieved: her non-verbal behaviour conveyed apprehension about getting it wrong and, in the context of her interview performance, being seen to get it wrong. Throughout the interview it was difficult to obtain examples of actual

decisions made, and the basis for these. The brief extracts below are taken from extremely lengthy responses, in which Stella seemed more concerned to establish her own credibility in the view of others, and according to others' prescriptions of what mattered, than with any decisions of her own.

Stella: …I usually begin, when I have students with me, to ensure that they've actually observed me in practice, to see the sort standards that I feel are acceptable, and that we've reflected on things…

…you need to say to the student, "OK, you take control here. You do the communicating, tell the patient what you're gonna be doing. And I'll stand back, and I'll critically analyse you…

What stood out in these statements was the formal language, typical of current policies and approaches to initial and continuing nurse education programmes. This includes the terms "standards", "reflected", "critically analyse", terms which Stella deployed throughout the interview when describing her approach to facilitating appropriate learning. That the latter term was used inappropriately in this context indicated that she was not entirely at ease with this model of learning, but chose to demonstrate that she was aligned with it. No doubt her uncertainty was exacerbated by finding herself being interviewed by (in her perception) someone representing the official position. Thus, she seemed to be strongly influenced by powerful others in expressing her ideas, but lacked the conviction to commit herself to a definitive decision. The territorialization (Deleuze and Guattari 1988) of nursing practice and knowledge by powerful others made Stella uncertain of her ground; consequently her ability to come to a clear decision was impaired: she seemed to see herself as lacking the authority to make one.

It is worth recalling from previous chapters that several participants construed their judgements in terms of “feeling” knowledge rather than in discrete cognitively defined elements. For instance, the following comment came from Mena, who was confident, when asked about it in a second interview, that she could justify her decision to fail a student.

Mena(2): … you know, if I feel, and I’ve got valid reasons, erm, I don’t really mind the fact, if they come back to me, and ask me as a mentor, why I made that decision …

Such statements articulated observations which defied rationalistic interpretation, and opposed the contemporary definition of practice, so potentially reducing her influence alongside managerialist notions of competence/ies. While some practitioners, like Stella, wanted to be seen to identify with the rationalistic camp, others wanted their views to be accepted as valid in their own right. As a consequence they were finding themselves at a disadvantage when conveying their decisions, even though they had confidence in their own judgements. While most also spoke of the desire to share, rather than dominate, decisions, such confidence was quickly qualified by allowing that tutorial staff may be better placed to make an overarching decision, since they would know the student across the whole programme. Counterbalancing this to some extent, Tina claimed the right to make a particular judgement where this concerned a clinical issue, even if she could not necessarily insist on its being carried through to ultimate failure of a student.

Tina(2): I can only base it on what I’ve seen here. But, like I said, if it was

serious enough then, yes, I would in[sist]…

Shortly before this, Tina had characterised the relationship between clinical and college staff as separate and equal, each with their own authority, rather than as inferior-superior, and this was evident in the way she described her decision-making process. She emphasised that her decisions were made on a context-specific basis, whereas tutorial staff's decisions were made more globally. If her decision were accepted, it could be defended as situationally important; if not, it could be understood as an aberration in the student's overall performance. On the matter of authority to decide, this was confirmed with the comment.

Tina(2): It really does depend on the situation… if the student has done something… which is against the law then, yes, I would insist on it, because I'd seen it, and that's that. But if it's … a practice that could be improved on, or they just hadn't had the experience to do it, then that's different.

Here, then, she appeared more certain of her position, when it might invoke a programmable decision (Derrida and Caputo 1997), based on the law – a ready-made criterion, necessarily shared between observers regardless of location. Previously she had proposed that judgement was based on context-dependent expertise. Earlier, application of the general rule would be unjust when applied to the particular; now, however, judgement of the particular may not do justice to the general, at least for the individual concerned. Accordingly vacillation prevailed; a little time later she said,

Tina(2): *[Pause]* Well, I think again, it's because it's just a short period that they're here for … because it's such a short period it might just be a weakness that person has got all the way through. Therefore me telling them [*college staff*] is yet another person telling them that this person's got a weakness. Or it just might be that that person's just having a bad

7 weeks, which is, which does happen…

Her explanation neatly performed undecidability: for her, both decisions were possible. Despite her attempts at clarification there was obvious uncertainty about whether she had the authority to declare a student as failed based on her own observed evidence. In the current context this should have carried considerable weight, but she was also apparently acting with deference to a more authoritative judge, however indeterminate the latter's authority might be over a particular instance.

Toni made similar points in a lengthy, virtually uninterrupted exposition during her second interview. On this occasion she laid great emphasis on her ward-based role, and thus the view that her ultimate responsibility was to the patients, and to her employer *vis-à-vis* management of the ward and its resources. Accordingly, she reserved the right to dominate any decisions concerning unsatisfactory practice – issues to do with appropriate application, involvement with patients, poor practice – but willingly deferred to academic judgement on theoretical matters. Overall decisions should be left, in her view, to tutorial staff, because they have ownership of programmes, whereas practitioners do not. In this extract, "paperwork" appears to symbolise this.

Toni(2): …it is our responsibility then to tell the tutor. The tutor then deals with the paperwork. That's the link I think. I think we've both got a joint responsibility for identifying whether that student is safe and competent. But the fact that the college tutor holds the reins in regards to the paperwork, so she actually would, say, fill in the paperwork, and say, "No, we're taking this person off the course." We don't have that…that authority…

Toni(2): They have an ownership of the course: the student is shared, and together I think the college and the practitioner decide on the student's competence. But it would actually be the college that removes the student from the course, not the practitioner.

This was an interesting response, in that she acknowledged her right to decide on unacceptable practice, whereas removal (the ultimate consequence of failure) was someone else's responsibility. She was clearly saying that she would always have the authority to exclude someone from her clinical area in the interest of her patients, but returned to the avoidance of condemnation of the student seen in terms of responsibility to the other. In addition, and consistent with these claims, in the following comment she also seemed to suggest that she herself needed no understanding of theory, apparently rejecting the emphasis on formalised rationalistic knowledge as a basis for initial preparation. This claim effectively removed her authority to assess "theoretical" knowledge, even in practice.

Toni(2): Yeh, and I … can tell who's going to make a nurse within a very short time: how they interact with the patients… Because, some nurses don't gain their diplomas and their degrees and their masters 'til they're in their 40s and 50s. So I would see it, I see th... the theoretical side you can nurture over time. But the actual practical side of it has to be there before they qualify.

Once more here was evidence of contradiction but of a different kind. Earlier she had stated that she considered herself academically weak; nevertheless, although she claimed authority in practice, she was willing to allow others to make the decision to exclude. For her, as for others, the problem may be one of insufficient confidence with a newer form of expression, despite her extensive experience. She did not appear willing, as it were, to put herself on trial by

making an overarching decision to fail a student. It was in effect the propositional, theorised version of nursing knowledge which excluded her.

A third participant interviewed a second time was Mena. Like Tina, she showed confidence in the validity of her own judgements, but was less certain about the extent to which they would drive final decision-making. Her view was similar to those of Tina and Toni in this respect, but she highlighted as a particular concern the general lack of feedback experienced when a student had been reported as failing, as this left her not knowing how her judgement had been taken. She did not know whether her views had been dismissed, used as a basis for remedial action, or led to discontinuation. It was clear that she saw herself as a *de facto* outsider to this process, apparently lacking the (gift of) authority to make final decisions. She was also, like Tina, in favour of sharing decision-making, but did not see much evidence of this in practice. She reported a lack of feedback on any negative decisions she and her colleagues had made (see chapter five). Hence, this comment points to the imposition of responsibility to monitor without authority to decide.

> Mena(2): …it's got to be a joint decision really, not just all laid on the college, because they don't get to see the practical experience when they're out [...] [but for] the practical experience of their placement, a lot of the responsibility's got to be on the mentor really.

Her point was that despite her own acceptance of responsibility for decisions about practice, her willingness to engage with the process was not reciprocated, and judgements might, therefore, be subject to some other criterion than safe or acceptable practice. She speculated on how this might

occur, and it was clear to her that college staff were the preferred option for students when any disputes arose. She suggested that the tutor was seen as the student's friend in the learning project, whereas the practitioner might be a problem!

Mena(2): … it's their *[the students']* backbone, I think; they don't know me. And their personal tutor, they've got very close to, and might have built up 12, 18 months, erm, good relationship with the person – and I think the college always tells them, too, if there's any problems, come back to us! *[laughs at this]*

This situation poses a particular difficulty for clinical staff. It would appear from Mena's experience that tutorial staff's relationship with the student is developed at the expense of a similar relationship with practitioners. The non-proximity of the other in the relationship between practitioners and tutors contrasts with the face-to-face quality (*cf*. Levinas 1969) of the relationship between tutor and student depicted by Mena, and allows decisions to be made in the mutual interest of tutor and student.

CONCLUSION

This chapter has considered the kind of dilemmas – aporias, to use Derrida's term (Derrida 1995) – experienced by practitioners when making their judgements. Rules of practice behaviour and performance, whether practitioners' own or the given assessment criteria, only ever provide a guide: the practitioner is called upon to make judgements rather than programmable decisions. The instances cited in this chapter are consistent with the background of uncertainty about the nature of their knowledge base, and the way they constructed their own discourse of practice and their own identities,

explored in previous chapters. They were caught between the technicised version of practice promoted in policy and the obligation to the others in their relationships within practice. There was a moral interest in this, a responsibility to the student as always-becoming-other. There was also an obligation to the profession and its regulatory body. If they deferred to the official discourse of practice, they omitted a consideration of the student as an individual. They are called on to make comparable decisions about students, implying a standardised outcome, yet their practice is a situated one. Neither students nor practice are standard; this rendered directly comparable judgements impossible.

They also struggled with their authority actually to make decisions. This brought into question the legitimacy of their own models for practice: whether to work to these or to defer to the powerful interests, *ergo* the interested authority, of professional others. The lack of authorisation to make decisions, in some accounts at least, seemed to be linked to what they saw as their *de facto* exclusion from the process of decision-making, but could also be explained as a consequence of their lack of familiarity, hence confidence, with the language of contemporary representations of practice knowledge. By articulating their understanding in more dispositional or intuitive terms they would lose ground in the face of the managerialist discourse of current policy and programme outcomes. Many also talked in a way that implied that their decisions, especially to fail someone, might reflect the quality of their input as a mentor-assessor in practice: some participants were not entirely at ease with me as the interviewer, seeming to see me in an inspectorial role.

There is a reflexive moment underlying both the process and the outcome of decision-making – an obvious awareness of the range of practical (situated) and discursive (approved) considerations which must be accommodated, and of others which must be avoided; of the incompleteness of data available to the individual observer; and of practitioners' own vulnerability in taking a decision to pass or to fail. Practitioners' own discourse of practice has shown the impossibility of applying a universal set of rules to particular instances of action and circumstance. Here, then, is the impossibility of decision-making leading to the suspension of any putative given, whether officially or personally defined. Given the complexity of the practitioner's view of practice, there are so many legitimate alternatives for making a decision, that – at least in some instances – practitioners (would) prefer not to make one at all.

Chapter 8: Conclusions and recommendations

INTRODUCTION

I suggested as a starting point for this study that there may be some conflict between, on the one hand, the model for assessment of students' developing practice promoted by policy, and how practitioners themselves account for their judgements, on the other. Differences were subsequently illustrated through my analysis of the stories given by participants. A more mutually acceptable model, hence a possible reduction in concern expressed about apparent inconsistencies so widely reported throughout the preceding decade, would necessarily involve acceptance of the legitimacy of differing kinds of understanding. In particular the practitioner perspective must be seen as situated, not absolute, and as responding to the demands of different contexts. Indeed many of the situations in which they are called upon to make judgements were found to be undecidable (Derrida 1995).

I showed through my analysis of associated literature that there is considerable congruence between the development of nurse education policy – a centrally driven model imposed on the individual – and the model of policy development described by Bauman (1999), despite appearances to the contrary. Bauman considers that we have experienced the loss of an effective public forum – the *agora* – for debates about policy formation and refinement, where differences and challenges to thinking can be worked out. Indeed, one might question whether nursing has ever really experienced such an arena. The approach to

assessment, and thus the model of practice to be adopted, was ostensibly developed through an open, inclusive debate. However, chapter two demonstrated that this was dominated by the managerialist interest, and that aspects of practice which do not conform to the dominant measurement and visibility model were effectively excluded from consideration.

Taking insights from Foucault's writing (Foucault 2002a) I argued that a positivistic understanding of nursing work, articulated as so-called competencies, came to dominate thinking about professional practice. However, the concept of competencies was rejected as inadequate for describing nursing work. I also argued that this positivistic understanding misses the point that the notion of competence is better regarded as what Deleuze and Guattari (1994) call a virtual concept, distinguishing this from its functive counterpart. Functives, as Drummond (2001) has argued, are unsuccessful attempts to actualise virtuals as concrete states of affairs. Accordingly I adopted the term acceptability to refer to the purpose of practitioners' judgements.

While professional work has come to be equated with visibility, Strathern (2000, p.309) has argued that this is no more than a "tyranny of transparency", manifested in the claim by powerful others to the authority to make the invisible visible (*cf.* Foucault 1973). Such claims are justified by the need, for instance, to ensure public safety – the primary *raison d'être* of the governing body – by removing variability and uncertainty from professional judgement. Concerns about the risk to safety in such variability were countered in this study by

practitioners' own discourse, which emphasised a concern with safeness, as well as their own interest and credibility, and with promoting good rather than merely adequate practice. The kind of judgements articulated in the accounts explored here are necessary, otherwise professional training becomes mere preparation of rule-bound technicians, with implications for both clinical and nurse-educational practitioners. Without them, any claim to expertise, hence to professionalism, is lost, despite the subtlety of practitioners' practices.

FINDINGS OF THE PRESENT STUDY: A SUMMARY

My initial approach to analysis arose from a relatively rationalistic starting point, and a desire to make explicit the criteria on which judgements were based. This showed how practitioners appeared to use a rationalistic process, understood through attribution and correspondence theory, when ascribing acceptability to students' performance (Jones and Davies 1965). This choice was an initial attempt to understand how participants linked evidence – in the form of visible behaviours – to what seemed to be the principal criterion, disposition, highlighted in their accounts of assessment. Incremental gains in knowledge and skill were expected, but were consistently explained as resulting from behaviours seen to be the consequence of appropriate disposition combined with opportunity. That is, assessment appeared to be concerned with the *approach* to learning about nursing work rather than with absolute achievements in their own right. Only where the absence of appropriate actions, or lack of knowledge gain, could not be explained by reference to circumstances would a fail decision be considered.

However, further examination of participants' accounts helped me to see that they pointed to more than the simple selection and application of preferred criteria. Their accounts were performing certain work for them (Potter 1997). It became evident that they were conscious of the impact of their decisions on those they were judging, and of the implications of their decisions for their own status. That is, they drew comparisons between themselves and those they were observing when formulating a judgement, and were conscious of being watched by me (*cf*. Anderson *et al* 2001). Their acknowledgement of knowledge and skills gains as part of their considerations neatly accommodated the technical-rational model of practice lauded by current policy, and appeared initially to be secondary to disposition.

This took me to the next phase in the analysis, in which I was able to recognise a less rationalistic process operating. Insights from Foucault's work (e.g. Foucault 2002a) allowed me to see that participants were constructing an alternative, multifaceted discourse of practice. This replaced the technical model with a convincing yet uncertain picture of their world. Their accounts resisted straightforward decision-making, acknowledging the variable but legitimate possibilities in any situation under observation. I came to see the initial rationality of practitioners' attributions – for instance, that a student's active engagement with opportunity was evidence of satisfactory disposition *ergo* development – as apparent only: judgements were neither simplistic and mechanistic, nor straightforward and unconsidered. Claims for a preference for dispositional over technical criteria was seen to allow greater movement in their judgements, justified on the grounds that it took more account of unpredictable

circumstance; it also allowed them to position themselves actively in relation to the prevailing discourse. Their model of practice was remarkably fluid, and they appeared to move rapidly along the rhizomes in their field of knowledge (Deleuze and Guattari 1988), making a plethora of different connections, so that judgements were always linked to the situation at hand, and never predetermined abstractions.

It was clear that practitioners considered safeness a primary concern; by highlighting self- and situational awareness, and linking these to the tendency to take appropriate action, they changed the absence of particular knowledge or skill into something to be addressed, rather than claiming it as a reason for failure. Disposition could be linked to the need for continuing development throughout one's career. Thus, their accounts indicated that they were anticipating future practice capability not merely present achievement: I eventually saw this as a concern with something-still-to-come. The emphasis on self- and situation-awareness matched to appropriate action preserved the importance of safeness, though this was much less dependent on correct deployment of technique than on the demonstration of sufficient humility to confirm judgements and understanding prior to action. Indeed, to my own surprise, it was rarely referred to in technical terms.

However, the choice of disposition as a key criterion also served to protect participants against charges of incompetence in their own practice. If deficits were a reason for failure, then any deficits in their repertoires, viewed against some arbitrarily defined indicator, could lead to charges of incompetence, and

thus undermine their own status, as well as their right to make such judgements. Concern with self-protection was understandable given that their accounts revealed that they experienced a strong sense of surveillance and distrust. Exclusion from final decisions on progression and continuation, and the absence of feedback on the outcome, when students had been judged negatively, seemed to provide confirmation of their alienation from the educational process. Indeed, lack of trust is illustrated nicely by the interesting paradox in professional training. Although nurses are trained to make complex decisions in clinical practice on a day-to-day basis, the increasingly explicit, reductive guidelines for assessment suggest a reluctance to accept that practitioners can make similarly complex judgements about another's approach to the same work.

Practitioners' discourse resisted the technical-rational model of practice, constructing knowledge about it differently, and judging students' performance according to situational demand and opportunity. Participants made a strong claim that one can never actualise the totality of practice, and that nurses are different things at different times. Consistent with this they constructed a remarkably mobile model of their nursing *personae* from which judgements of students were derived. The interviews provided an opportunity for these participants to construct themselves through the process of ascesis (Foucault 2000), often acknowledging that they had not previously been aware of their own multiplicity. The model they constructed bore comparison with Deleuze and Guattari's (1988) Body without Organs, an un-predetermined identity, variably constructed and reconstructed from related elements in their field, allowing

them to define themselves by association with an apparently immiscible *mélange* of knowledge, abilities, and attributes.

There was also a strong sense of moral responsibility towards the student as other in their relationship. As well as building a defensive function into their accounts, practitioners showed keen awareness that any judgement they made had consequences for the individual to whom it was applied, and a strong aversion to condemning him or her for any apparent failing. This was illustrated, for example, by the suggestion that someone might be better suited to another career, since each has her or his own strengths as well as weaknesses. The process by which they evaluated a student's performance showed marked similarities with the results reported by Anderson *et al* (2001) findings in relation to attributions of responsibility: they were clearly aware of the similarities between themselves and those they were judging.

Added to all other considerations it was then no surprise that decision-making was at best difficult, at worst impossible. A fixed criterion for determining acceptability – that is, judging the other according to a unitary model of the practitioner or of practice – could not take account of the variable quality of clinical situations or settings, nor of the variable qualities inherent in nurses' *personae*, and so was suspended to allow an assessment of wider personal and situational factors. Participants' accounts indicated a concern with something in a state of flux, with something still to come, an example of the Deleuzian notion of individuals as always-becoming-other (Deleuze and Guattari1988; Deleuze 1994), rather than reaching a fixed state of identity; to

determine acceptability using a fixed model for comparison would be unjust (Derrida 1995).

Hence, on one level, practitioners utilised attribution and correspondence principles (Jones and Davies 1965), and appeared to be complying with a rationalistic model; but insights from postmodernist writers such as Foucault (2002a, 1977b), Derrida (1995; Derrida and Caputo 1997), Deleuze and Guattari (1994, 1988), Potter (1996; Potter and Wetherell 1987) and others have shown that there is marked resistance to a unitary and rational model. Participants constantly anticipated something-still-to-come – judging potential, perhaps, rather than absolute achievement – but were nevertheless concerned with safe, appropriate, and professional practice. Indeed, by judging something-still-to-come they demonstrated the non-closure of the Deleuzian distinction between virtual and functive concepts; completion is an aspiration not a state of affairs which can be actualised (Drummond 2002; Deleuze and Guattari 1994).

Since practice, for this group of practitioners at least, was explained as a situated phenomenon, hence variable in its operation, so situated accounts of their judgements allowed them to claim a more authentic, more dynamic understanding of student development than lists of acontextual behaviours permit. Pre-specified action was held as inappropriate; indeed, wherever the commonplace caveat ‘appropriate’ is associated with any assessment criterion, there is already an invitation to use judgement rather than programmed decision-making. In practitioners’ accounts lists of competencies provided, at most, only a guide to the *kind* of achievements to be sought in students’

practice. Such lists remain an impoverished representation of a complex, context-bound practice, and propose an inappropriately standardised understanding of what counts as acceptable.

Reflections: research and personal development

I commenced this study thinking that it would be useful to identify what the notion of competence might mean to practitioners. This, of course, implied a realist view of the practitioners' world, and that something fairly discrete and definable could be found. It came as something of a revelation that they did not seem as concerned with a technical, rationalistic model, as I had expected; indeed, I was struck by the indeterminacy and tentative nature of their stories. In thinking through this I had to recognise first of all that our relationship in the interviews, hence how they chose to respond, was influenced by their perception of me, regardless of how I saw this. However, I also had to recognise that I had possibly been working with certain assumptions, about how practitioners might understand practice capability or account for what they do in assessment, which I had not properly acknowledged. In retrospect, I had been assuming an impracticable schism between knowing and doing and being a nurse in different contexts. This may have arisen from what I perceived as a profound difference between their area of work, general adult nursing, and my own field, mental health nursing; this was – to me at least – a much more obviously indeterminate area of activity than its companion.

This was interesting to me, in that, even prior to this undertaking, I had not been comfortable with a policy which seemed to promote an approach to education,

in which my role as teacher was a kind of production technician, dealing in given explanations for what are always situated events. Despite the relocation and restructuring of nurse training introduced in the 1990s, it seemed to me that the opportunity for a genuinely critical approach to nursing knowledge was being lost in the pursuit of professional status, equated for the time being with a rationalistic understanding. I had moved into what I now recognise as that uncertain territory at the boundary of discursively approved knowledge, in which transgression is performed as a struggle between resistance and retreat. It was exciting to find an ally in practitioners' own articulation of their work, especially given that they came from a different area of clinical practice from my own background.

Finally, explaining situated judgements required a shift of thinking on my part, and was evident in the change of approach to analysis. Initially, I saw the data relatively straightforwardly as a more relevant version of what mattered to practitioners. However, the significance of the constant movement in their stories became more apparent, through a combination of influences: challenging questions from my supervisor(s), to which I had to respond; my own reading, which disturbed more conventional thought; staying with the data, and remaining open to the possibility of alternative options presenting themselves. The process has developed my appreciation of what in another context is called the uncertainty principle, in the pursuit of good quality practice and justice to the individual in assessment.

IMPLICATIONS FOR THE ASSESSMENT OF PRACTICE

On the basis of these accounts practitioners' claims are more sophisticated and adaptive than the approach promoted in policy; indeed they more closely match the so-called holistic model of practice promoted through both education and policy, since they actively take account of all available factors. Practitioners described their work as necessarily situated, *ergo* contingent, and demonstrated ability to evaluate student performance in terms of professionalism in relationships, appropriate application of knowledge and skills, and safeness. The use of a rhizomatic form of knowledge, invoked according to the demands of particular situations, showed that pre-specification is too limiting in such assessments. Predetermined outcomes lead to inconsistency precisely because they are predetermined yet must be applied in variable contexts (*cf*. Edgoose 2001). Practitioners require freedom to roam (Drummond 2002) in assessment, to report performance on their own terms.

Assessment based on narrative reports reviewing situated performance therefore needs to replace competency-based statements of outcome. These and their euphemistic substitute, proficiencies (NMC 2004), must be rejected as an inadequate characterisation of practice. The specification of outcomes did not facilitate practitioners' search for what they described as good, safe practice. Beyond the domain of applied practice, participants readily deferred to the right of tutorial staff to determine achievement in the academic domain. However, participants pointed to their own practice in which knowledge was translated and drawn upon according to its application. Assessment is

concerned with a student's ability to select and apply understanding appropriately – held to be part of nurses' day-to-day practice – and is better captured through narrative, open assessments.

In the interest of good practice, then, nurse education policy needs to replace the politico-economic emphasis on a sterile, product-orientated model with a focus on professionalism based on adaptive responding. This has two consequences. It enables nurse educators to adopt a process orientation, and to promote the development of knowledgeable and skilled but self-aware, self-motivated individuals who will work with the uncertainty of complex problems, building their knowledge base as they encounter new experiences. It also recognises practitioners' expertise by acknowledging their understanding of the practice context, instead of subjugating this to artificial, managerialist definitions. This equalises the relationship between clinical and educational practitioners, facilitates a healing of the academic-practice division, by removing the power differential – perceived or otherwise – between the two camps, and enables a more egalitarian dialogue where failure is to be considered.

Nonetheless, an important purpose of assessment is to distinguish the acceptable from the unacceptable. How, then, does a student fail? Participants identified the interdependence of engagement and incremental gain, without predetermining what would be gained, except inasmuch as it related to particular encounters. This is not refusal to discriminate, but recognition of the fluid nature of practice situations, which have to be judged individually. Such judgements are central to practitioners' involvement and cannot be determined

in advance. If certain discrete elements can be prescribed, as some participants indicated, then these *may* be specified and assessed independent of context; such (technical) elements are unproblematic, as programmable decisions. However, where repeated judgements of practice as a situated activity do not lead to appropriate engagement to rectify any identified deficits, then, importantly, a cumulative decision to fail will result.

Practitioners' situated perspective should lead practice-based judgements, in a way that makes their expertise in the application of knowledge genuinely central to decisions on capability (*cf.* WNB 1997; UKCC 1999), rather than merely appearing in the rhetoric of programme design. Visibility may be a political necessity, but we cannot disguise the indeterminacy of clinical situations in any but the most straightforward of these. Exemplars derived from practitioners' accounts of assessment *in situ* need to replace current outcome specifications as a guide for assessment, but without predetermining it. Combined with practitioner accounts of individual student performance these offer a more appropriate basis for comparability and demonstration of equivalence – witness the examples cited by practitioners in this study – while recognising the fluid nature of professional judgement. However, we should be clear that these do not provide a reason for censure of the assessor, nor limit the articulation of professional work to a fixed range of options. Practitioners must have, and know that they have, authority as well as freedom to judge according to need rather than context-free specification, recording judgements in contextualised narratives.

The model of professional identity proposed by participants in this study, in which they actively constituted themselves as incomplete multiplicities, is consistent with the un-predetermined approach needed for assessment of performance, and provides a central plank for programme design. Analysis of clinical situations in their totality requires nurses to draw on different ways of being in order to find a suitable response. This Body without Organs (Deleuze and Guattari 1988) does several things. It promotes an understanding of nurses and nursing as not belonging to one category or another, and so retains a focus on flexible, discretionary responding (*cf*. Wade 1999); it supports continuous personal and professional development; it promotes good nursing based on judgement of individual need, by emphasising the need to address more than technical aspects of a problem. Narrative reports based on situated performance promote continuous development, whereas lists of prescribed outcomes, since these cannot predict all possibilities, encourage the perception and pursuit of absolute achievement as a once for all event.

The development and inclusion of exemplars necessitates a greater degree of engagement with the process of programme development than was evident from the accounts reported here. Policy already requires involvement of practitioners, but there are difficulties with this, which leave it currently at the level of rhetoric. I demonstrated in chapter three the considerable difficulty I experienced in obtaining participants for this study: availability is subject to strong organisational and personal pressures. These same pressures must apply to participation in planning, so that involvement of practitioners to date has been peripheral. Second, I showed that participants were comfortable in

their own clinical domain, but uncomfortable with the academic orientation of training programmes (though this does not deny their understanding of the clinical context). Programmes are written in terms familiar to education establishments, but which are not in clinical practitioners' terminology; planning committees tend to be dominated by academic representatives, and so do not always provide the most comfortable forum for expression of dissent.

A less territorial approach to programme development, which goes beyond the mere geographical location of the planning process, is therefore necessary. For instance, link tutors or lecturer-practitioners, who already have a presence in clinical areas, could provide the forum (*cf*. the *agora*: Bauman 1999) for discussion on means and ends in practice learning, and replace reliance on the impracticable option of identifying a separate time and space for this purpose. Absence (hence *de facto* exclusion) from planning meetings has led to practitioners being faced with impracticable – sometimes incomprehensible – options when assessing progress. The approach proposed here strengthens appreciation of practitioner expertise (*cf*. Fish and Coles 1998), aiding the productive exercise of judgement, rather than perpetuating more defensive ploys for fear of censure. If practitioner perspectives can be obtained by other means, then a more authentic, hence meaningful, understanding can find its place in formal documentation, increasing practitioners' sense of ownership of assessment processes. It is then a relatively straightforward matter to invite practitioners to approve or modify the documents they will be expected to use in practice.

For policy makers there will be concerns about participants' evident hesitation in making a firm decision on a student's performance; policy has a legitimate concern with safeness, a major factor driving the specification of outcomes. However, hesitation does not jeopardise safety where a fiduciary relationship exists, both between nurse and patient or client, and between policy-makers and practitioners. The hesitation seen in this study arises in part from practitioners' perceived vulnerability – for instance, in failing to facilitate successful learning, or indicting themselves *vis-à-vis* knowledge deficits. More positively, it derives from the particularity of situations encountered, and the need, prominent in participants' commentaries, for safety combined with justice. Practitioners' own preparation and status provides the impetus for judicious decision-making: participants would not jeopardise their own position through incautious pronouncements. Policy-makers must accept that pre-specified outcomes create two paradoxes. First, there is an increase in hesitation, since outcomes check practitioner as well as student performance; second, outcomes potentially lead to unsafe practice, since, when viewed as a once for all achievement, they can discourage continuous and repeated evaluation in the student. It is necessary therefore to allow practitioners to make situated, un-predetermined judgements, and to refrain from imposing abstracted criteria, precisely in the interest of safeness.

It has been proposed that clinical and educational practitioners engage in a dialogue as the basis for assessment (MacAleer and Hamill 1997), and is recommended in policy guidelines as good practice. However, this presents a logistical problem, in that people need to be present to each other for dialogue

to occur; numbers of students, multiple locations, and resource limitations mean that this is unlikely to happen. The possibility therefore remains that practitioners' judgements can be overruled in response to other pressures; following Levinas' (1969) notion of responsibility to the other, it is the face-to-face encounter which removes this possibility. In the absence of a direct encounter between tutorial and practice staff, the condition arising between practitioner and student will not emerge; so decisions are as likely to serve the interest of external pressures as to support practitioners' judgements on acceptability.

Once more, this necessitates trust in professional colleagues' judgements as the basis of decisions on progression, and a shift of authority in their favour. As an example, practitioners in this study showed that failure to apply or develop practice knowledge through engagement can be read as unacceptable or unsafe, since it has implications for both present and future practice capability and security. Where deficits were identified, concern turned to whether a student responded appropriately to remedy this. Such examples, incorporated into assessment reports as proposed above, provide evidence to support the judgement; this preserves the visibility criterion required by policy makers and managers by making explicit the rationale for final decisions. Because the concept of practice, as opposed to procedural elements of it, can only properly be understood as a situated phenomenon, there cannot be fixed criteria for decision-making. To limit practitioners' options presents them with an impossible task, itself unjust, which should be removed from the process.

Final comments

If it is to be used at all, the notion of competence in practice should be reclaimed – de-territorialized, in Deleuze and Guattari's (1988) terms – and restored to its global meaning, recognised as a virtual not a functive concept, concerned with *overall* capability, a much more fluid condition than implied by prescriptive outcomes. While assessment is based on putatively discrete, measurable, objective outcomes of learning, nursing denies the fluid nature of its own practices, and leaves control in the hands of politically motivated others. Educational practitioners are well placed to encourage this more fluid understanding, since it fits the open, questioning approach traditionally promoted by higher education. An alliance of clinical and educational practitioners provides a broad base from which to challenge the technical-rational perspective of managerialism. Though recently the two camps have been separated by the modernist pursuit of knowledge and its representation, the data here suggest that they have more in common with each other, than they have differences with a managerialist perspective. The relationship between policy-makers and education providers has required that nurse teachers somewhat uncritically implement the wishes of powerful others, despite their professional status. Acquiescence to the modernist preference both misrepresents a non-rationalistic practice, and places an impossible burden on educationalists and clinical practitioners alike. A more productive alliance *vis-à-vis* the nature of nursing knowledge and its deployment in practice opens the way for a (re)awakening of the debate about the purpose of educational practices: to emancipate or reproduce. Nurse teachers, in my view,

have a professional obligation to promote criticality; recognition of uncertainty does not equate to unsafe or unprofessional practice. A new alliance promises to redress nursing's power-invested relations in favour of practice, both educational and clinical.

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Appendix A: Initial interviews (guidance notes)

State: "When you, or any of your colleagues, are assessing a [pre-reg.] student, you are being asked to judge whether that student's practice is reaching an acceptable level [for continuation or registration]. In doing this you have to make sense of a wide range of different things, and then record a judgement about whether that student's practice is acceptable."

Emphasise: "I am making NO judgement about rightness or otherwise of statements / actions."

State: "Can you think about students you have had contact with as far as possible – rather than hypothetical ones. What made you decide what you did about that student? If it helps, you might want to think of 3 possible 'students'; you could think about them separately or altogether, whichever suits you better."

Prompts (if participants have difficulty in getting started):

1. A good student who will make a good nurse:
    - What was s/he like?
    - What made you decide s/he was OK?
    - What was the most obvious aspect of her/his performance?
    - Was this important – and, if so, why?
    - Is this something you would record *explicitly*?

- Were there any *supporting* elements / evidence for your judgement?
- Were there any *conflicting* aspects of performance?
- (If relevant or arises in response) Is this what makes someone *competent* (or moves them towards it)?

2. Someone you did not wish to "pass" / see progress.
    - How did this person differ from the first? What was the problem?
    - What evidence did you use / look for?
    - What would have been needed to change your judgement?
    - Were there any aspects of performance which were OK? Why did *[the identified element]* override others?
    - Why is *[the identified element]* important here?
    - Where does this come from?
    - How does it link to the idea of *competence*?

3. Someone you were unsure about.
    - What was the problem?
    - What did you decide? What evidence did you use?
    - Why is this important? Where does it come from?
    - Would your colleagues have made the same judgement? How do you know?
    - How does this relate to your idea of good / acceptable nursing practice?
    - How does any/all of this connect with the idea of *competence in practice*?

4. How are things / judgements recorded?
    - Whose language do you use – your own or “official” / given?
    - How authentic are recorded statements?
    - Do you have any preference for how you record judgements? (Are there any *differences between*, say, checklists and more narrative *forms*?)

Appendix B: The participants

Abby, health visitor
Qualified 15 years, now at degree level, a registered nurse, midwife and health visitor. Student supervisor and assessor for most of that time. Invited as a one-off to allow for a possible 'outsider' view, since health visitors only get early stage students, and for short periods of experience. Tended to emphasise mainly communicative ability, and building relationships. Clear that she saw a distinction between being competent at something in particular, and being a competent nurse as more global.

Bron, district staff nurse
13 years experience since qualification, with additional community qualification at Dip HE level. She had also started her career as an enrolled nurse, and obtained first level qualification later. Worked alongside, and acted as student assessor for over 5 years. Appeared a little apprehensive about my purpose and initially her responses were rather hesitant and brief, requiring more prompting than previous interviewees. Nonetheless, she became more relaxed subsequently and was better able to expand on responses as time went on.

Grace, district sister
Having started her career as an enrolled (2^{nd} level) nurse, she had upgraded her qualification to first level some 12 years ago, now holds a community nursing degree, and was recently appointed to a sister grade. Regularly worked with students for several years in her current role. Appeared a little nervous, possibly as to the purpose of the research. Facial gestures during the interview seemed to indicate that she was looking for reassurance that she was responding in the appropriate way; nevertheless, she settled into developing her views about the points she raised.

Marje, staff nurse
Qualified 3 years to DipHE level, and working towards degree qualification. Assessing students regularly for past 2 years. On initial contact seemed nervous about recording of interview, and sought assurance about the informality of the style of the interview. Appeared self-conscious about her initial nursing qualification as diploma, rather than degree. Identified the approach to assessment as her own, based on her conception of "good practice". First to raise the idea of her "feel" for knowledge.

Maisie, staff nurse
Qualified 9 years, in pre-Project 2000 scheme; studied various short clinical modules relevant to her work, and has been a student supervisor for 2 years. Quite diffident in expressing ideas, and found it difficult to extend her responses without explicit prompting. Did not seem to be a supporter of the current form of training, with reduced time in practice. Seemed on edge throughout our conversation, and relieved when it was over.

Mavis, staff nurse
Qualified for 13 years, in pre-Project 2000 programme, but has not continued in formal education, other than related clinical training. Has supervised students for 5 years. Appeared confident expressing her ideas, but gave the initial impression that she felt the interview was likely to be a 'test' of some sort. Seemed keen to emphasise concrete aspects of performance early on in he interview, but moved away from this and seemed confident in expressing ideas, though ambivalent about the theoretical element.

May, staff nurse
Qualified 3 years with Dip HE, now regularly involved in assessing students over the last 2 years. Quite nervous about being recorded, and requested some reassurance at the start. Recognised the difficulty of defining the "everyday", but settled into her own views, and appeared to stay with her own ideas, as opposed to trying to guess mine. Did not use sophisticated language or jargon like some others; despite this some of her comments were eloquent in their simplicity and apparent honesty, and she provided a useful definition of common sense.

Megan, ward sister
Over 30 years experience since qualification, and involved in student development and assessment for many of those years. Had undertaken updating training, but held no higher qualification. Very thoughtful throughout the interview, frequently taking time out to formulate ideas before expressing them. Found that this was not as straightforward as she had expected. Spontaneously suggested a colleague who might offer an alternative view, having been trained much more recently – an interesting anticipation of the presence of difference in nursing knowledge and practice.

Mena, staff nurse
6 years experience following initial diploma level qualification; followed this with various additional clinical modules. Very involved with student learning and assessment for over 3 years. Seemed a little apprehensive prior to interview, and may have felt some pressure initially to participate. Showed surprise when ½ hour had passed, and she still had more to say. Quite able to explore ideas without much prompting, and was confident abut the basis of her own judgements. Invited for re-interview following her comments about lack of feedback and lack of feeling involved and valued by academic colleagues.

Molly, district sister
20years experience in practice following initial qualification. Now holds degree in her specialist field, with several years experience of supervising pre- and post-registration students. Very easy to engage with the process of exploration, and appeared confident and open about her perspective on desirable qualities, attributes, and achievements in students and how she would know these, but gave no sign of dismissing others' perspectives on this. Located her comments explicitly in a community setting. Sometimes came over as giving an interview performance.

Nan, staff nurse
Qualified 6 years with an initial diploma, now working towards a full degree, and keen to continue working with and assessing students as she has for 4 years. Discovered the difficulty of articulating the “obvious” and everyday, but seemed to find this personally interesting. Once she had identified her own ideas, she talked spontaneously of the complexity of judgements, which were always context-dependent. Drew a clear distinction between competence as minimally acceptable and technical, and good practice as more rounded performance.

Nerys, senior staff nurse
Qualified 9 years, achieved immediately prior to introduction of Project 2000 programmes. Involved with student assessment for over 5 years. Very edgy about being recorded, but seemed to talk quite freely once started, and demonstrated a clear understanding of the purpose of the enquiry. Conveyed a view of assessment as complex, and of “good” students as more than technically able, readily using herself as a model to illustrate her view of practice.

Nina, ward sister
Qualified for 27 years, now to degree level, with several additional professional qualifications, currently working towards a masters degree. Routinely received and supervised students through her ward for over 10 years. Contacted through my colleague, though stated that she had intended to respond to my original circulated letter. Quite self-assured, keen to participate in the project, willing and able to talk and explore issues. Came to recognise that articulating what she sought in students was not as easy as she had thought, and insisted on the complexity of judgements involved.

Rena, district sister
20 years experience in practice, and qualified subsequently with DipHE in community nursing. Regularly had students for several years studying at both degree and diploma levels. Very willing to talk, locating her views in a community context. Freely acknowledged that her time out of hospital was a possible source of difference between her own and others’ perspectives. Slipped into “you know” commentary on a number of occasions, apparently assuming my prior understanding of her view. Seemed quite secure, and sought no reassurance throughout our conversation.

Sandy, nursing home sister
Qualified 11 years, pre-Project 2000, now studying towards an initial Dip HE award; the only participant currently working in mental health care. Has been a student mentor-assessor intermittently for most of that time. Very pleased to get involved, an open and expansive talker! Located her ideas in the context of her particular working area. Came up with one or two useful characterisations of the demands of good practice (she was first with the monkey analogy for skills acquisition). Presented an interesting balance of technical and personal considerations quite explicitly according to context.

Stella, district sister
10 years experience post-qualification, 6 in community nursing, actively pursuing further studies now working towards her degree. Possibly the most discursively conscious participant; throughout the interview she seemed keen to establish that she was “on the right lines”, using a considerable amount of formal jargon. A change of tone was noticeable towards the end of the interview, which seemed to reveal a more personal, less discursively driven, view.

Toni, ward sister
Qualified 23 years, also a midwife, and subsequently obtained degree of MA. Now with a managerial role in her hospital unit; started her career as an enrolled nurse. Has supervised students for over 10 years. Easy to get talking, and keen to set judgements in her own context. Picked up on any prompts quite freely, but seemed very concerned to cover all possible angles. Second time around had a clear managerial orientation: chosen for re-interview particularly following her apparent concern with accountability on the first occasion.

Tina, ward sister
Qualified 14 years, another participant who started her career as a second level nurse, converted later, and now completing degree level study. Supervised and assessed students for 9 years. Though generally she seemed quite confident in expressing her view of good and poor practice, she made some interesting, ambivalent references to different kinds of knowing (evidence-based vs. gut feeling), and was invited for re-interview for this, as well as her deference to college staff’s authority to decide finally on students’ continuation or otherwise.